

FILED AUG 27 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

28623

State File No. \_\_\_\_\_

318

1003

Registrar's No. 7316

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 1003		Registrar's No. 7316			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE _____ b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) St Louis MO		c. LENGTH OF STAY (in this place) 11		c. CITY (If outside corporate limits, write RURAL and give township) St Louis MO		600			
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital				2. STREET ADDRESS (If rural, give location) 2825 W. Delaware Blvd					
3. NAME OF DECEASED (Type or Print) a. (First) Hattie b. (Middle) Trauson c. (Last) (Transer)			4. DATE OF DEATH (Month) (Day) (Year) August 20 1949						
5. SEX Female		6. COLOR OR RACE Cauc		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Not known about 70			
9. AGE (in years) (If under 1 year: Months) (If under 12 hrs.: Hours) (Min.) 70		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cannon Miss. 17			
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME Fessick Jones		13b. MOTHER'S MAIDEN NAME O'Leary		14. NAME OF HUSBAND OR WIFE Second			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Florence Cottrell 2825 Delaware					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION Decompensation Arteriosclerotic Heart Disease with Cerebral Thrombosis Hypertension				INTERVAL BETWEEN ONSET AND DEATH Undet.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION							
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 1020			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? HtH X					
22. I hereby certify that I attended the deceased from 8-19, 1949, to 8-20, 1949, that I last saw the deceased alive on 8-20, 1949, and that death occurred at 4 p. m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) James J. Hedrick M. D.				23b. ADDRESS 2601 N Whittier St		23c. DATE SIGNED 8-22-49			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8-26-49		24c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis MO			
DATE REC'D BY LOCAL REG. AUG 22 1949		REGISTRAR'S SIGNATURE J. B. Casater		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. L. Beal 2726 Lucas Ave					

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*Theodore J. Yendell*

Licensed Embalmer No.

*4243*

P. O. Address \_\_\_\_\_

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**