

FILED OCT 7 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31969
State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8351**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY <i>St. Louis</i>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (in this place) 5 yrs		d. STREET ADDRESS (If rural, give location) 21 - 2210 Delmar	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Lois		b. (Middle)		c. (Last) McCoy		4. DATE OF DEATH (Month) (Day) (Year) Sept. 26 1949	
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5. SEX Female <i>♀</i>		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced		8. DATE OF BIRTH 6-8-1921		9. AGE (In years last birthday) 28		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser		10b. KIND OF BUSINESS OR INDUSTRY Cleaning Plant		11. BIRTHPLACE (State or foreign country) East St. Louis, Ill.		12. CITIZEN OF WHAT COUNTRY? USA	
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13a. FATHER'S NAME Jacob Driadel		13b. MOTHER'S MAIDEN NAME Idella Morris		14. NAME OF HUSBAND OR WIFE	
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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.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Veola Driadel 1250 Aubert	
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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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Meningitis - etiology Undetermined ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Undetermined DUE TO (c). II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None		INTERVAL BETWEEN ONSET AND DEATH Undet.	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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) <i>St. Louis</i>	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 3403	
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22. I hereby certify that I attended the deceased from 8-23, 1949, to 9-26, 1949, that I last saw the deceased alive on 9-26, 1949, and that death occurred at 5:10a. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <i>James I. Hedrick M.D.</i>		23b. ADDRESS 2601 N Whittier St.		23c. DATE SIGNED 9-27-49	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Sept. 28, 1949		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) East St. Louis ILL.	
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DATE REC'D BY LOCAL REG. SEP 28 1949		REGISTRAR'S SIGNATURE <i>J. B. Foster</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>J. L. Marshall E. St. Louis, Ill.</i>	
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[Handwritten mark]

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 *Thomas M. Johnson* _____

Licensed Embalmer No. *4479* _____

P. O. Address *St Louis, Mo* _____

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.