

THE DIVISION OF HEALTH OF MISSOURI

FILED OCT 27 1949

STANDARD CERTIFICATE OF DEATH 1003

State File No. 35217
Registrar's No. 8796

318

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		a. STATE Missouri	
c. LENGTH OF STAY (in this place)		b. COUNTY	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1429a N. Vandeventer Av.		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
		d. STREET ADDRESS (If rural, give location) 1429a N. Vandeventer Ave.	

3. NAME OF DECEASED (Type or Print)	a. (First) Rosa	b. (Middle) Stubbs	c. (Last) Hedgepath	4. DATE OF DEATH (Month) (Day) (Year) 10/10/49
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5. SEX Female 3	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2	8. DATE OF BIRTH Unknown--1887	9. AGE (In years last birthday) Abt. 62	IF UNDER 1 YEAR Months Days	IF UNDER 4 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) St. Louis Missouri	12. CITIZEN OF WHAT COUNTRY? U.S/A
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13a. FATHER'S NAME Henry Thomas	13b. MOTHER'S MAIDEN NAME Ellen Moore	14. NAME OF HUSBAND OR WIFE Stewart Hedgepath
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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) -----	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Elizabeth Gardner 1429 N. Vandeventer
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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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH 6yr
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u>		
	DUE TO (c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			331X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 2	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) 102
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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? HIT BY
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22. I hereby certify that I attended the deceased from Jan 31, 1947 to Oct 11, 1949, that I last saw the deceased alive on _____, 19____, and that death occurred at 10:30 AM from the causes and on the date stated above.

23a. SIGNATURE Sam Stefford	(Degree or title)	23b. ADDRESS 925 N. Jefferson Avenue	23c. DATE SIGNED
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 10/13/49	24c. NAME OF CEMETERY OR CREMATORY Chicago	24d. LOCATION (City, town, or county) (State) Illinois
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DATE REC'D BY LOCAL REG. OCT 13 1949	REGISTRAR'S SIGNATURE J B Susant	25. FUNERAL DIRECTOR'S SIGNATURE Gates Funeral Home, 4107 Finney Av	ADDRESS
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(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 _____

John K. Cunningham

Licensed Embalmer No. 4476

P. O. Address 4107 Finney Avenue

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.