

FILED OCT 28 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35370

State File No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9013**

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|--|--|--|-----------|
| 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 OR TOWN St. Louis, U) | | a. STATE Missouri | b. COUNTY |
| c. LENGTH OF STAY (In this place) | | c. CITY (If outside corporate limits, write RURAL and give township) St. Louis 17 | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital | | d. STREET (If rural, give location) 2712 Howard | |

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|-------------------------------------|----------------|------------------|-----------------|--|
| 3. NAME OF DECEASED (Type or Print) | a. (First) Joe | b. (Middle) Anna | c. (Last) McCoy | 4. DATE OF DEATH (Month) (Day) (Year) Oct. 16 1949 |
|-------------------------------------|----------------|------------------|-----------------|--|

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|-----------------|--------------------------|--|----------------------------|------------------------------------|------------------------|----------------------------|
| 5. SEX Female 3 | 6. COLOR OR RACE Colored | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow 2 | 8. DATE OF BIRTH Oct. 1877 | 9. AGE (In years last birthday) 72 | IF UNDER 1 YEAR Months | IF UNDER 2 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) Pocahontas, Arkansas | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
|---|-----------------------------------|--|-------------------------------------|

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| 13a. FATHER'S NAME Pete Bailey | 13b. MOTHER'S MAIDEN NAME Elmira Bailey | 14. NAME OF HUSBAND OR WIFE Deceased |
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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. None | 17. INFORMANT'S SIGNATURE OR NAME Mrs. Clytus M. Goodwin | ADDRESS 2617 St. Lawrence |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | MEDICAL CERTIFICATION | | INTERVIEW BETWEEN ONSET AND DEATH |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Mechanical Obstruction with Gangrene | DUPLICATE | | Undet. |
| ANTECEDENT CAUSES | DUE TO (b) Undetermined | | |
| *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death. | DUE TO (c) Hypertension | | |

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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) 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 checked="" type="checkbox"/> | 21f. HOW DID INJURY OCCUR? 444X |
|---|--|---------------------------------|

22. I hereby certify that I attended the deceased from 6-3-1949, to 10-16-1949, that I last saw the deceased alive on 10-16-1949, and that death occurred at 8:45a m., from the causes and on the date stated above.

| | | | |
|---------------------------------------|-----------------------|---------------------------------|---------------------------|
| 23a. SIGNATURE Montague Lawrence M.D. | (Degree or title) (D) | 23b. ADDRESS 2601 N Whittier St | 23c. DATE SIGNED 10-17-49 |
|---------------------------------------|-----------------------|---------------------------------|---------------------------|

| | | | |
|--|--------------------|--|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE 10-20-49 | 24c. NAME OF CEMETERY OR CREMATORY Washington Park | 24d. LOCATION (City, town, or county) (State) St. Louis, Mo. |
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| DATE REC'D BY LOCAL REG. OCT 20 1949 | REGISTRAR'S SIGNATURE J.B. Foster | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS G.T. Nash 3847 Page |
|--------------------------------------|-----------------------------------|--|

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 _____

Licensed Embalmer No. 20432

P. O. Address 384 Page

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.