

FILED NOV 5 1949

THE DIVISION OF HEALTH - MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **35681**  
9260BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MO.</b> b. COUNTY <b>St. Louis</b>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) <b>5 yrs.</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>1522 Cole St</b>				d. STREET ADDRESS (If rural, give location) <b>25 - 1522 Cole</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>FRANCES</b>			b. (Middle) _____		c. (Last) <b>Washington</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>10 25 1949</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed 2</b>	8. DATE OF BIRTH <b>Aug. 15, 1893</b>		9. AGE (in years last birthday) <b>56</b>	IF UNDER 1 YEAR Months <b>2</b> Days <b>10</b>	IF UNDER 24 HRS. Hours <b>-</b> Min. <b>-</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DOMESTIC</b>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <b>Mississippi</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13a. FATHER'S NAME <b>UNKNOWN</b>			13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		14. NAME OF HUSBAND OR WIFE <b>LEWIS Washington</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT'S SIGNATURE OR NAME <b>George JACKSON</b> ADDRESS <b>1522 Cole</b>			
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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Hypertensive Heart Disease</b>						INTERVAL BETWEEN ONSET AND DEATH _____
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Apoplectic Left Side</b>						
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) <b>St. Louis MO</b>			
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? <b>Heart</b>			
22. I hereby certify that I attended the deceased from <b>Jan. 4<sup>th</sup> 1949</b> to <b>Oct 25<sup>th</sup> 1949</b> , that I last saw the deceased alive on <b>Oct. 25</b> , 1949, and that death occurred at <b>6:30 p.m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>Franklin L. Rowan M.D.</b> (Degree or title)				23b. ADDRESS <b>1681 Franklin Ave.</b>		23c. DATE SIGNED <b>Oct. 27, 1949</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>10-31-1949</b>	24c. NAME OF CEMETERY OR CREMATORY <b>OAK Dale</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis MO</b>		
DATE REC'D BY LOCAL REG. <b>OCT 28 1949</b>		REGISTRAR'S SIGNATURE <b>J. B. Casater</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Chas. R. Howes</b> ADDRESS <b>2812 Carg Ave.</b>			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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. Chas. S. No.

P. O. Address 2812 Cav. Ave.

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

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