

FILED NOV 25 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

318 G. PHILLIPS HOSP 1003

38449

State File No. 9923

Registrar's No.

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

3. NAME OF DECEASED (Type or Print) Sadie	a. (First)	b. (Middle)	c. (Last) Adams	4. DATE OF DEATH Nov. 11 1949
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5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH July 28, 1909	9. AGE (In years last birthday) 40	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 15 MIN. Hours
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Aberdeen, Miss.	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME Jerry Box	13b. MOTHER'S MAIDEN NAME Alice McGee	14. NAME OF HUSBAND OR WIFE Clyde Adams
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Norene Walton	ADDRESS 2712 Clark
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis and		
	ANTECEDENT CAUSES Bronchial Pneumonia		
II. OTHER SIGNIFICANT CONDITIONS Undetermined			

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) 83
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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? 332X
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22. I hereby certify that I attended the deceased from 11-8, 19 49, to 11-11, 19 49, that I last saw the deceased alive on 11 Nov. 11, 19 49, and that death occurred at 12 N m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) James J. Hedrick D. III	23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 11-14-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Nov. 18, 1949	24c. NAME OF CEMETERY OR CREMATORY Washington Pk.	24d. LOCATION (City, town, or county) (State) St. Louis Mo
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DATE REC'D BY LOCAL REG. NOV 19 1949	REGISTRAR'S SIGNATURE J. B. Patsler	25. FUNERAL DIRECTOR'S SIGNATURE English Und. Co	ADDRESS 2931 Lucas
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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 *Buelson English*

Licensed Embalmer No. *4208*

P. O. Address *2931 Lucas, etc*

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.