

FILED JAN 3 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 42653
10959

BIRTH 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 Mo b. COUNTY St. Johns Sta.					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 1 Week		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Johns Sta.		d. STREET ADDRESS (If rural, give location) 3330 Marshall Ave			
d. FULL NAME OF HOSPITAL OR INSTITUTION Mo. Baptist Hosp.				d. STREET ADDRESS (If rural, give location) 3330 Marshall Ave					
3. NAME OF DECEASED (Type or Print) a. (First) Julia		b. (Middle) Wash		c. (Last) Kidd		4. DATE OF DEATH (Month) (Day) (Year) Dec 20, 1949			
5. SEX F		6. COLOR OR RACE W		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Oct. 8, 1859			
9. AGE (In years last birthday) 90		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) St. Louis Co., Mo.		12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME Martin J Wash			13b. MOTHER'S MAIDEN NAME Margaret Humphrey			14. NAME OF HUSBAND OR WIFE Peyton E. Kidd			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (No, no. or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Carrie K Hemphill 3330 Marshall ave					
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broncho-pneumonia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral hemorrhage DUE TO (c) Arterio-sclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 6 days 14 days 10 yrs			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) 97					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 331X					
22. I hereby certify that I attended the deceased from Nov 10, 1949 , to Dec 20, 1949 , that I last saw the deceased alive on Dec 20, 1949 , and that death occurred at 6:10 am. , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) Maurice A. Bisher MD				23b. ADDRESS 8924 St. Charles St. St. Louis, Mo.				23c. DATE SIGNED 12/21/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Dec 22, 1949		24c. NAME OF CEMETERY OR CREMATORY Bellefontian Cem		24d. LOCATION (City, town, or county) (State) St. Louis Mo.			
DATE REC'D BY LOCAL REG. OFFICE DEC 21 1949		REGISTRAR'S SIGNATURE J. B. Pasater		25. FUNERAL DIRECTOR'S SIGNATURE Alexander Sons		ADDRESS 6175 Helmer			

(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 *Jos. E. McCulloh*

Licensed Embalmer No. *2460*

P. O. Address *617 1/2 Pilma*

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.