

FILED DEC 27 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

43038  
State File No. 10693  
Registrar's No.

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____	
d. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>	
c. LENGTH OF STAY (in this place) <u>6 1/2</u> yrs		d. STREET ADDRESS (If rural, give location) <u>25 - 1433 Franklin Ave. (rear)</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Homer G Phillips Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Loubertha</u> b. (Middle) _____ c. (Last) <u>Vanarsdell</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>12 11 1949</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>April 7, 1900</u>
9. AGE (In years last birthday) <u>49</u>		IF UNDER 1 YEAR Months <u>8</u> Days <u>4</u>	IF UNDER 24 HRS. Hours <u>4</u> Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>La.</u>
12. CITIZEN OF WHAT COUNTRY? _____			

13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. <u>497-03-5112</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Arcola Johnson</u> ADDRESS <u>1433 Franklin</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriolar Nephrosclerosis</u>		DUE TO (b) <u>Hypertensive Heart Disease</u>		Undet.	
ANTECEDENT CAUSES		DUE TO (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.		II. OTHER SIGNIFICANT CONDITIONS			
		Conditions contributing to the death but not related to the disease or condition causing death.			

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) <u>930</u>	
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? <u>44.3K</u>	

22. I hereby certify that I attended the deceased from 10-22, 1949, to 12-11, 1949, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at 1:31 1/2 p.m., from the causes and on the date stated above.

23. SIGNATURE <u>James J. Hedrick</u> (Degree or title) <u>M. D. V.</u>		23b. ADDRESS <u>2601 N Whittier St</u>		23c. DATE SIGNED <u>12-12-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>12-13-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Oakdale Cemetery</u>	
				24d. LOCATION (City, town, or county) (State) <u>Lemay, Mo.</u>	

DATE REC'D BY LOCAL REG. <u>DEC 12 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Parster</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>E. B. Poole</u> ADDRESS <u>1221 N. Grand</u>	
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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 *Clarence Croshaw*

Licensed Embalmer No. 4755

P. O. Address \_\_\_\_\_

**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.