

S. No. 200
v. 10-49

FILED JAN 26 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2769
539

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No.

BIRTH NO. _____

1. PLACE OF DEATH
a. COUNTY _____

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Missouri
b. COUNTY _____

b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis

c. LENGTH OF STAY (in this place) Undet.

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Homer G Phillips Hospital

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2199
0

d. STREET ADDRESS (If rural, give location) 4447 Delmar

3. NAME OF DECEASED (Type or Print)
a. (First) Mary
b. (Middle) _____
c. (Last) McLendon

4. DATE OF DEATH (Month) (Day) (Year)
Jan. 2 1950

5. SEX Female 3

6. COLOR OR RACE Colored

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Wid. 2

8. DATE OF BIRTH Unknown

9. AGE (In years last birthday) 80?

If UNDER 1 YEAR: Months _____ Days _____

If UNDER 1 HRS. Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil

10b. KIND OF BUSINESS OR INDUSTRY _____

11. BIRTHPLACE (State or foreign country) Unknown

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Not known

13b. MOTHER'S MAIDEN NAME Not known

14. NAME OF HUSBAND OR WIFE Same address Emma Graham, Cousin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown

16. SOCIAL SECURITY NO. Unk

17. INFORMANT'S SIGNATURE OR NAME ADDRESS
Elizabeth Rhodes, 2601 N Whittier St

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) Cerebral Arteriosclerosis and Thrombosis

INTERVAL BETWEEN ONSET AND DEATH 3 mos

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis

DUE TO (c) None

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION _____

19b. MAJOR FINDINGS OF OPERATION _____

20. AUTOPSY? YES NO

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)
332X

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from 9-4, 1949, to 1-2, 1950, that I last saw the deceased alive on 1-2, 1950, and that death occurred at 2:15p m., from the causes and on the date stated above.

23a. SIGNATURE James J. Hedrick (Degree or title) M. D.

23b. ADDRESS 2601 N Whittier St

23c. DATE SIGNED 1-4-50

24a. BURIAL, CREMATION, REMOVAL (Specify) in

24b. DATE JAN 18 1950

24c. NAME OF CEMETERY OR CREMATORY Anatomical Board

24d. LOCATION (City, town, or county) (State) St. Louis, Mo.

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE [Signature]

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Rowland Mortuary Service Inc.

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

009
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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body of _____ 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. _____

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.