

FILED FEB 24 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 6888  
1358  
Registrar's No. ....

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

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

1. PLACE OF DEATH a. COUNTY <u>None</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>None</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Saint Louis</u>	
c. LENGTH OF STAY (in this place) <u>2 yrs</u>		d. STREET ADDRESS (If rural, give location) <u>11 1803a Goode Avenue</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Homer G Phillips Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Julia</u> b. (Middle) _____ c. (Last) <u>Whitlock</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>2-8-50</u>		
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	
8. DATE OF BIRTH <u>7/1/1874</u>		9. AGE (in years last birthday) <u>75</u>		10. IF UNDER 1 YEAR Hours Min. <u>7 7</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Hopkinsville, Kentucky</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					

13a. FATHER'S NAME <u>Tom Sommers</u>		13b. MOTHER'S MAIDEN NAME <u>Ida --unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Steve Whitlock</u>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Lelia Campbell</u>	
				ADDRESS <u>1803a Goode Ave</u>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Generalized Arteriosclerosis</u>  ANTECEDENT CAUSES <u>Cerebral Thrombosis</u> DUE TO (b) _____ DUE TO (c) _____ Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Undet.</u>  <u>"</u>
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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) <u>332X</u>	
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?	

22. I hereby certify that I attended the deceased from 2-2, 1950, to 2-8, 1950, that I last saw the deceased alive on 2-8, 1950, and that death occurred at 11:45pm., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>James J. Hedrick</u>		23b. ADDRESS <u>2601 N Whittier St</u>		23c. DATE SIGNED <u>2-10-50</u>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>2/13/50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Washington Park Cem.</u>	
				24d. LOCATION (City, town, or county) (State) <u>St. Ferdinand County, Mo.</u>	

DATE REC'D BY LOCAL REG. <u>FEB 10 1950</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles J. Gates</u>	
				ADDRESS <u>4107 Finney Ave.</u>	

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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed.....

*John K. Cunningham*

Signed.....

Student Embalmer

Licensed Embalmer No. 4476

P. O. Address 4107 Finney Avenue

**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.