

FILED JUN 9 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18033

State File No. 1751

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	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis	c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. LOUIS 2219	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3307 Lawton Ave.		d. STREET ADDRESS (If rural, give location) 3307 Lawton Ave.	

3. NAME OF DECEASED (Type or Print) a. (First) JANE b. (Middle) Buckner c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) 5-24-50			
5. SEX Female 3	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED 27	8. DATE OF BIRTH Dec. 25, 1873	9. AGE (In years last birthday) 76 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) NIL	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Arkansas	12. CITIZEN OF WHAT COUNTRY? yes	

13a. FATHER'S NAME Peter White	13b. MOTHER'S MAIDEN NAME Hannah	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Peter Horton ADDRESS 2149 Stalrud

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) Hypertensive Heart Disease ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH 3 months
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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)
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? H2O X

22. I hereby certify that I attended the deceased from **15 Feb**, 19 **50**, to **May**, 19 **50**, that I last saw the deceased alive on **19 May**, 19 **50**, and that death occurred at **7:30 p** m., from the causes and on the date stated above.

23a. SIGNATURE Edna Moore (Degree or title)	23b. ADDRESS 4501a Easton Ave	23c. DATE SIGNED 26 May
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 5-29-50	24c. NAME OF CEMETERY OR CREMATORY Washington Park
24d. LOCATION (City, town, or county) (State) St Louis County Mo.	25. REGISTRAR'S SIGNATURE J B Foster	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Bennedoe - 3102 Washington
DATE REC'D BY LOCAL REG. MAY 29 1950		

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 H. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 4575 Aldine

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.