

FILED MAY 23 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1003

State File No. 18467

1362

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. \_\_\_\_\_ Registrar's 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) ST. LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) 2217 OR TOWN ST. LOUIS 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 2702 GAMBLE ST	

3. NAME OF DECEASED (Type or Print) Sadie	a. (First)	b. (Middle)	c. (Last) Monroe	4. DATE OF DEATH (Month) (Day) (Year) May 11 1950
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5. SEX FEMALE	6. COLOR OR RACE COLORED	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH FEB. 5, 1885	9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months	IF UNDER 6 HRS. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) ST. LOUIS, MISSOURI 0	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME HENDERSON YOUNG	13b. MOTHER'S MAIDEN NAME LETTIE	14. NAME OF HUSBAND OR WIFE
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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)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Lula C. Banks	ADDRESS 2717 SHERIDAN
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Undet.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c)		
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 <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)
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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? 4200
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22. I hereby certify that I attended the deceased from 5-8, 1950, to 5-11, 1950, that I last saw the deceased alive on 5-11, 1950 and that death occurred at 1 p.m., from the causes and on the date stated above.

23a. SIGNATURE Lula C. Banks	(Degree or title)	23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 5-12-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) 11	24b. DATE 5-17-50	24c. NAME OF CEMETERY OR CREMATORY WASHINGTON PARK	24d. LOCATION (City, town, or county) (State) ST. LOUIS CTY MO
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DATE REC'D BY LOCAL HEALTH DEPT. MAY 16 1950	REGISTRAR'S SIGNATURE J B Foster	25. FUNERAL DIRECTOR'S SIGNATURE A.F. WALTON	ADDRESS 2707 STODDARD ST
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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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed

*Arthur L. Heulhard*

Signed.....  
Student Embalmer

Licensed Embalmer No. 4221

P. O. Address 40 49 St Terence

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.