

FILED AUG 14 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6703

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 Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis Mo		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2119	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 4003 Cote Brillante	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Lillie b. (Middle) Flowers c. (Last) Givens			4. DATE OF DEATH (Month) (Day) (Year) August 2 1950		
5. SEX 3 Female		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow 2	
8. DATE OF BIRTH 3/4/1900		9. AGE (In years last birthday) 50		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 4 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Benoit, Mississippi	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME West Flowers		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Mathew Givens	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Julius Givens, 4003 Cote Brill.	
17. ADDRESS					

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) Uremia		DUE TO (b) Hypertension				Undet.	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) Undetermined				"	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death		Rheumatic Heart Disease					

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)			
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? 444X			

22. I hereby certify that I attended the deceased from 7-30, 1950, to 8-2, 1950, that I last saw the deceased alive on 8-2, 1950 and that death occurred at 11:10 pm, from the causes and on the date stated above.

23a. SIGNATURE C. Robinson M. D.		23b. ADDRESS 2601 N Whittier St		23c. DATE SIGNED 8-4-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8/8/50		24c. NAME OF CEMETERY OR CREMATORY Washington Park Cem.	
				24d. LOCATION (City, town, or county) (State) St. Louis, Missouri	

DATE REC'D BY LOCAL REG. AUG 7 1950		REGISTRAR'S SIGNATURE J. B. Foster		25. FUNERAL DIRECTOR'S SIGNATURE Chas. J. Gates, 4107 Finney Avenue	
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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.....

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.