

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUL 29 1950

State File No. **24909**
Registrar's No. **6224**

BIRTH NO. _____ REG. DIST. NO. **310** PRIMARY REG. DIST. NO. **1003**

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

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. LENGTH OF STAY (in this place) 30 yrs	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		e. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
		f. STREET ADDRESS (If rural, give location) 2717 Clark	

3. NAME OF DECEASED (Type or Print) Alice	a. (First)	b. (Middle)	c. (Last) January	4. DATE OF DEATH (Month) (Day) (Year) July 17 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 March 1899-01-51	9. AGE (In years last birthday) 51	if UNDER 1 YEAR Months	if UNDER 1 YEAR Days	if UNDER 1 MIN. Hours	if UNDER 1 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house keeper	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Shelby, Miss.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Will Sharp	13b. MOTHER'S MAIDEN NAME Edna January	14. NAME OF HUSBAND OR WIFE not known
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Jessie Banks ADDRESS 439 Everett Kansas City, Kas
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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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinom of Breast with extensive		ndet
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Undetermined DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		Surgical Absence of left Breast	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 170X
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22. I hereby certify that I attended the deceased from **7-10**, 19**50**, to **7-17**, 19**50**, that I last saw the deceased alive on **7-17**, 19**50**, and that death occurred at **9:45a** m., from the causes and on the date stated above.

23a. SIGNATURE M. D. Lawrence (Degree or title) M. D.	23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 7-18-50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7-20-50	24c. NAME OF CEMETERY OR CREMATORY Washington Park	24d. LOCATION (City, town, or county) (State) St. Louis, Mo
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DATE REC'D BY LOCAL REG. Jul 20 1950	REGISTRAR'S SIGNATURE J. W. Lassiter	25. FUNERAL DIRECTOR'S SIGNATURE A. H. Bond and Co ADDRESS 2726 Purcell
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JUL 29 1950

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.....
Student Embalmer

Signed Leroy W. Bannister

Licensed Embalmer No. 4523

P. O. Address 3880 Coaton Ave

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.