S. No. 300
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FILED AUG 14 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24924

State File No. 6735

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2710 Mills Street

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
d. STREET ADDRESS (If rural, give location): 2710 Mills street

3. NAME OF DECEASED (Type or Print)
a. (First): Luella
b. (Middle):
c. (Last): Jones

4. DATE OF DEATH (Month) (Day) (Year): Aug. 3, 1950

5. SEX: female
6. COLOR OR RACE: Colored
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: Feb. 11, 1909
9. AGE (In years last birthday): 41 — If under 1 year: Months 5, Days 23 — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housekeeper
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Columbis, Miss.
12. CITIZEN OF WHAT COUNTRY?:

13a. FATHER'S NAME: Hamp Huggins
13b. MOTHER'S MAIDEN NAME: Luella Brown
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.: 49-01-0742
17. INFORMANT'S SIGNATURE OR NAME: Fannie Nickerson
ADDRESS: 3127 A. Franklin

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma Breast & Uterus — INTERVAL BETWEEN ONSET AND DEATH: ?

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.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: None
20. AUTOPSY? YES ☐ NO ☒

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 ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: 170X

22. *I hereby certify that I attended the deceased from* 7/11, 1950, *to* 8/3, 1950, *that I last saw the deceased alive on* 8/2, 1950, *and that death occurred at* 5 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): E. J. Frazier M.D.
23b. ADDRESS: 3126 Chouteau
23c. DATE SIGNED: 8/3/50

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 9, 1950
24c. NAME OF CEMETERY OR CREMATORY: Greenwood cem.
24d. LOCATION (City, town, or county) (State): St. Louis County Mo.

DATE REC'D BY LOCAL REG. AUG 8 1950
REGISTRAR'S SIGNATURE: J. B. Sasater
25. FUNERAL DIRECTOR'S SIGNATURE: Dement & Son
ADDRESS: 2629-31 Cole Stree

(Licensed Embalmer's Statement on Reverse Side)

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 W. Claude Gordon

Licensed Embalmer No. 3989

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.