S. No. 300
v. 10-48

FILED SEP 15 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28411

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7609

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) 1706 Cole 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, 2259
d. STREET ADDRESS (If rural, give location) 25 1706 Cole Street 0

3. NAME OF DECEASED (Type or Print)
a. (First) Norma
b. (Middle) Hogan
c. (Last) Lockhart

4. DATE OF DEATH (Month) (Day) (Year) Sept. 6, 1950

5. SEX 3 female
6. COLOR OR RACE Colored
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Oct. 19, 1913
9. AGE (In years last birthday) 36 — IF UNDER 1 YEAR Months 10 Days 24 — IF UNDER 24 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) St. Louis, Mo. 0
12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME Ben Hogan
13b. MOTHER'S MAIDEN NAME Hallie Grady
14. NAME OF HUSBAND OR WIFE Oscar Lockhart
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT'S SIGNATURE OR NAME ADDRESS Oscar Lockhart 1706 Cole Street

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) Cancer (With [illegible])

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

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
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? 170 X

22. *I hereby certify that I attended the deceased from* 5/1/50, 19__ *to* 9/5, 1950, *that I last saw the deceased alive on* 9/5/50, 19__, *and that death occurred at* 3:10 am *p.m., from the causes and on the date stated above.*

23a. SIGNATURE W C Bridges 0 (Degree or title)
23b. ADDRESS 941 N Sarah St
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) burial 0
24b. DATE Sept. 11, 1950
24c. NAME OF CEMETERY OR CREMATORY Washington Park cem.
24d. LOCATION (City, town, or county) (State) St. Louis county, Mo.

DATE REC'D BY LOCAL REG. SEP 8 1950
REGISTRAR'S SIGNATURE J. B. Lasater
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Dement & Son 2629-31 Cole Street

(Licensed Embalmer's Statement on Reverse Side)

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

X Primary Pulp Brick

Name
book

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. 3485

P. O. Address 45-75 Alabama

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.