

STANDARD CERTIFICATE OF DEATH

State File No. **34607**
Registrar's No. **8433**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		11. STREET ADDRESS (If rural, give location) 1016 N. Cardinal Ave.	

3. NAME OF DECEASED (Type or Print) a. (First) Elmira b. (Middle) c. (Last) Boyd			4. DATE OF DEATH (Month) (Day) (Year) Oct. 3, 1950		
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH May 29, 1893	9. AGE (In years last birthday) 57	IF UNDER 1 YEAR Months Days Hours Min. 4 4
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Greenville, Miss.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.					

13a. FATHER'S NAME Willis Key		13b. MOTHER'S MAIDEN NAME Ella Welch		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.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Carrie Bryant 3014a Easton Ave.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Anemia - Hypochromic 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.		INTERVAL BETWEEN ONSET AND DEATH Undet.	
--	--	---	--	---	--

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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 291X	

22. I hereby certify that I attended the deceased from **10-1**, 19 **50**, to **10-3**, 19 **50** that I last saw the deceased alive on **10-3**, 1950, and that death occurred at **4:05 p. m.**, from the causes and on the date stated above.

23a. SIGNATURE Lorena Harris M. D.		23b. ADDRESS 2601 N Whittier St.		23c. DATE SIGNED 10-3-50	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10-7-1950		24c. NAME OF CEMETERY OR CREMATORY Washington Park	
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.					

DATE REC'D BY LOCAL REG. OCT 6 1950		REGISTRAR'S SIGNATURE J. B. Pasch		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. H. Randle & Son 3133 Belle Ave.	
---	--	---	--	---	--

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.....

S. J. Watson

Signed.....

Student Embalmer

Licensed Embalmer No. *2698*

P. O. Address *2769 Charlotte*

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.