

FILED OCT 27 1950

STANDARD CERTIFICATE OF DEATH

State File No. 35292

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 8784

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		e. STREET ADDRESS (If rural, give location) 217 So. Jefferson	
3. NAME OF DECEASED (Type or Print) Mary Sanders		4. DATE OF DEATH (Month) (Day) (Year) Oct. 16 1950	
5. SEX 3 female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Jan. 5, 1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 50
11. BIRTHPLACE (State or foreign country) Alamo, Tenn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Wit Koonce		13b. MOTHER'S MAIDEN NAME Midgitt	14. NAME OF HUSBAND OR WIFE Sam Sanders
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 Altie Ruth Moore	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia		INTERVAL BETWEEN ONSET AND DEATH Undet.	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Hypertension	
		DUE TO (c) Arteriolar Nephrosclerosis	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		None	
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 HHTX	
22. I hereby certify that I attended the deceased from 10-10, 1950, to 10-16, 1950, that I last saw the deceased alive on 10-16, 1950, and that death occurred at 3:25 a.m., from the causes and on the date stated above.			
23a. SIGNATURE L. Carson Harrison M. D.		23b. ADDRESS 2601 N. Whittier St	23c. DATE SIGNED 10-16-50
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Shipped	10/19/50		Dyersburg Tenn.
DATE REC'D BY LOCAL REG. OFF. OCT 17 1950	REGISTRAR'S SIGNATURE J. B. Lancaster	25. FUNERAL DIRECTOR'S SIGNATURE Dunn F. Home 215 So. Jeff.	

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.....
Student Embalmer

Signed.....
John Watson

Licensed Embalmer No. *2698*

P. O. Address *2769 Chouka*

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.