

FILED NOV 17 1950

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. **38822**
 Registrar's No. **9300**

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

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

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) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 46		c. CITY (If outside corporate limits, write RURAL and give township) OR 2229 St. Louis 2229	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital			d. STREET ADDRESS (If rural, give location) 2729 Market St.		
3. NAME OF DECEASED (Type or Print) a. (First) Ella b. (Middle) May c. (Last) Mayberry			4. DATE OF DEATH (Month) (Day) (Year) Oct. 27 1950		
5. SEX Female 3	6. COLOR OR RACE Col.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2	8. DATE OF BIRTH March 25th, 1884		9. AGE (In years last birthday) (If under 1 year: Months) (If under 12 mos.: Days) (If under 1 min.: Hours) (Min.) 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nil		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Connersville, Tenn. /	
13a. FATHER'S NAME Buck Mayberry		13b. MOTHER'S MAIDEN NAME Eliza (unk)		14. NAME OF HUSBAND OR WIFE Phil Thompson	
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 Allen Brown ADDRESS 2729 Market	
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, ashenia, etc. It means the disease, injury, or complication which caused death.			MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis ANTECEDENT CAUSES DUE TO (b) Hypertension DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Undetermined		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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 332X	
22. I hereby certify that I attended the deceased from 8-4 , 19 50 , to 10-27 , 19 50 , that I last saw the deceased alive on 10-27 , 19 50 , and that death occurred at 2:15pm. , from the causes and on the date stated above.					
23a. SIGNATURE Laruso Harris (Degree or title) M. D.			23b. ADDRESS 2601 N Whittier St		23c. DATE SIGNED 10-30-50
24a. BURIAL CREMATION, REMOVAL (Specify) Burial		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY Washington Park	
24d. LOCATION (City, town, or county) (State) St. Louis County Missouri		DATE REC'D BY LOCAL REG. NOV 1 1950		REGISTRAR'S SIGNATURE J. B. Foster	
25. FUNERAL DIRECTOR'S SIGNATURE R.M.C. Green			ADDRESS 3517 Laclede Ave.		

ORIG MS

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 Melvin E. Green

Signed.....
Student Embalmer

Licensed Embalmer No. 4428

P. O. Address St. Louis, Mo.

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.