No. 300
10.48

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 39106

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 9257

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

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): Homer G. Phillips Hospital

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 2119
d. STREET ADDRESS (If rural, give location): 4216 W. North Market St.

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

4. DATE OF DEATH (Month) (Day) (Year): Oct. 29 1950

5. SEX: Female 3
6. COLOR OR RACE: Colored
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Feb. 5, 1857
9. AGE (In years last birthday): 93 — IF UNDER 1 YEAR Months: 8 Days: 24 — IF UNDER 24 HRS. Hours: Min.

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): Smith County, Tenn. 1
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13a. FATHER'S NAME: Jake Owens
13b. MOTHER'S MAIDEN NAME: Lucy ?
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): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Louise Webb 4216 W. North Market St.

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) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 8 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arterio Sclerosis — Unkn
DUE TO (c) Senility

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
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? 331 X

22. *I hereby certify that I attended the deceased from* 10/28, 1950, *to* 10/28, 1950, *that I last saw the deceased alive on* 10/28, 1950, *and that death occurred at* 12:30 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): S E Moore MD
23b. ADDRESS: 809 N Jefferson
23c. DATE SIGNED: 10/30/50

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 1, 1950
24c. NAME OF CEMETERY OR CREMATORY: Washington Park
24d. LOCATION (City, town, or county) (State): St. Louis County Mo.

DATE REC'D BY LOCAL REG.: OCT 31 1950
REGISTRAR'S SIGNATURE: J. B. Lassiter
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: J. H. Randle & Son 3133 Bell Ave.

(Licensed Embalmer's Statement on Reverse Side)

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.....

Signed.....
Student Embalmer

Licensed Embalmer No. 2698

P. O. Address 2769 Chaw

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.