

STANDARD CERTIFICATE OF DEATH

State File No. 2362

FILED JAN 19 1951

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 100 Registrar's No. 195

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. CITY (If outside corporate limits, write RURAL and give township) FOR TOWN St Louis	
c. LENGTH OF STAY (in this place)		2-2-19	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 1006 N. 20th Street	

3. NAME OF DECEASED (Type or Print) a. (First) Marie b. (Middle) Blackwell c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) Jan. 6 1951	
5. SEX F	6. COLOR OR RACE Col	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Separated	8. DATE OF BIRTH 9-30-1920
9. AGE (in years last birthday) 30	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Columbus Miss
12. CITIZEN OF WHAT COUNTRY? U.S.A		13a. FATHER'S NAME Lemon Hughes	
13b. MOTHER'S MAIDEN NAME Sallie McCrell		14. NAME OF HUSBAND OR WIFE Nathion Blackwell	

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.	17. INFORMANT'S SIGNATURE OR NAME Sallie Hughes	
		ADDRESS 1006 N. 20th St.	

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) Malignant Lymphosarcoma		INTERVAL BETWEEN ONSET AND DEATH Undet.	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES	
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Undetermined	
DUE TO (c)		DUE TO (c)	
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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR 11981

22. I hereby certify that I attended the deceased from 11-5, 1950, to 1-6, 1951, that I last saw the deceased alive on 1-6, 1951, and that death occurred at 12:50 P.M., from the causes and on the date stated above.

23a. SIGNATURE Barbara W. Harris	(Degree or title) M. D.	23b. ADDRESS 2601 N Whittier St.	23c. DATE SIGNED 1-8-51
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 1-10-51	24c. NAME OF CEMETERY OR CREMATORY Washington Park	24d. LOCATION (City, town, or county) (State) St Louis MO

DATE RECD. BY LOCAL REG. JAN 9 1951	REGISTRAR'S SIGNATURE J. B. Lanter	25. FUNERAL DIRECTOR'S SIGNATURE Gus Howe	ADDRESS 2930 Dickson
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.

Signed.....
Student Embalmer

Signed

Leroy H. Bannister

Student Embalmer No.

Licensed Embalmer No. 4523

P. O. Address 3880 Boston Ave

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.