

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

FILED JAN 31 1951

State File No. 2719
 Registrar's No. 599

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).			
a. COUNTY None		b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		a. STATE Missouri		b. COUNTY None	
c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis		d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips		STREET ADDRESS (If rural, give location) 4740 Kensington St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION _____		e. FULL NAME OF HOSPITAL OR INSTITUTION _____		f. FULL NAME OF HOSPITAL OR INSTITUTION _____		g. FULL NAME OF HOSPITAL OR INSTITUTION _____	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH		5. SEX	
a. (First) Matilda		b. (Middle) _____		c. (Last) Lee		Date: (Month) (Day) (Year) Jan. 19, 1951	
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 1/1/1918	
9. AGE (In years last birthday) 33		10. MONTHS 0		11. DAYS 18		12. HOURS 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____		10b. KIND OF BUSINESS OR INDUSTRY Landuary		11. BIRTHPLACE (State or foreign country) Mississippi		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME John Wade		13b. MOTHER'S MAIDEN NAME Cordia Nelson		14. NAME OF HUSBAND OR WIFE Willie Lee			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Cordia Wade ADDRESS 1105 Tudor Avenue			
18. CAUSE OF DEATH		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Ovary with Generalized Metastases				Undet.	
*This does not mean the mode of dying, such as heart failure, assthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES					
		DUE TO (b) _____					
		DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS					
		Conditions contributing to the death but not related to the disease or condition causing death. Intestinal Obstruction					
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) (Minute) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 175X			
22. I hereby certify that I attended the deceased from 11-29 , 19 50 , to 1-19 , 19 51 , that I last saw the deceased alive on 1-19 , 19 51 , and that death occurred at 3:55p m. , from the causes and on the date stated above.							
23a. SIGNATURE [Signature] (Degree or title) M. D.				23b. ADDRESS 2601 N Whittier St.		23c. DATE SIGNED 1-20-51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 1/19/51		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) East St. Louis, Illinois	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JAN 20 1951 [Signature]				25. FUNERAL DIRECTOR'S SIGNATURE P. Q. Criggler ADDRESS 1036 Tudor Avenue			

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed John K. Cunningham

Licensed Embalmer No. 4476

P. O. Address. 4107 Finney

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.