

FILED FEB 6 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH 1003

2981  
State File No. 840

318

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

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE _____ b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		2219	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Homer G Phillips</u>				e. STREET ADDRESS (If rural, give location) <u>3238 Olive Rear</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Tisha</u>		b. (Middle) _____		c. (Last) <u>Scott</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 24 1951</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>Black</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>Unknown</u>	
9. AGE (In years) (Month) (Day) (Year) <u>70</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>	
12. CITIZEN OF WHAT COUNTRY? _____		13a. FATHER'S NAME <u>Unknown</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME - ADDRESS <u>Tena Widson 3238 Olive Rear</u>			
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) <u>Hypertensive Cardiovascular Disease and Cerebral Thrombosis</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Undetermined</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u> <u>None</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Undet</u>	
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? <u>HH3 X</u>			
22. I hereby certify that I attended the deceased from <u>1-20</u> , 19 <u>50</u> , to <u>1-24</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>1-24</u> , 19 <u>51</u> , and that death occurred at <u>8:45a</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Farens W. Harris M.D.</u> (Degree or title)				23b. ADDRESS <u>2601 N Whittier St</u>		23c. DATE SIGNED <u>1-24-51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Jan 29/51</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo</u>	
DATE RECD BY LOCAL REGISTRAR'S SIGNATURE <u>J. B. Passton</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. B. Passton</u>		ADDRESS <u>4214 Delm F. Green</u>			

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.....

*Christal E. Lewis*

working under my personal supervision.

Student Embalmer No..... *408* .....

Signed..... *Christal E. Lewis* .....

Student Embalmer

Signed.....

*F. A. Mean*

Licensed Embalmer No..... *2963* .....

P. O. Address..... *4214 Delmar* .....

**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.