

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

6057

FILED MAR 2 1951

1003 State File No. 1545

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		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 <u>Missouri</u> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>St. Louis</u> )		c. LENGTH OF STAY (in this place) <u>15 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>2119</u> OR TOWN <u>St. Louis</u>		d. STREET ADDRESS (If rural, give location) _____			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Homer G. Phillips Hospital</u>				d. STREET ADDRESS <u>3214 1/2 Magazine St.</u>					
3. NAME OF DECEASED (Type or Print) <u>Ada Fears</u>			a. (First)		b. (Middle)		c. (Last)		
4. DATE OF DEATH <u>Feb. 10 51</u>			5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>unmarried</u>		
8. DATE OF BIRTH <u>Dec. 9, 1882</u>			9. AGE (In years last birthday) <u>68</u>		10. MONTHS <u>2</u>		11. DAYS <u>1</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>unemployed</u>		11. BIRTHPLACE (State or foreign country) <u>Aberdeen, Miss. /</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Ben Fears</u>			13b. MOTHER'S MAIDEN NAME <u>unknown</u>			14. NAME OF HUSBAND OR WIFE <u>none</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Edith Fears Johnson</u> ADDRESS <u>3214 1/2 Magazine</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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Renal failure (Uremia)</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 hrs</u>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>HYPERTENSION.</u>						?	
		DUE TO (c) _____							
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Recent Rt Hemiplegia</u>						<u>6 wks</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____						20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>334-X</u>					
22. I hereby certify that I attended the deceased from <u>Feb 7 - 19 51</u> , to <u>Feb 10, 19 51</u> , that I last saw the deceased alive on <u>Feb 9, 19 51</u> , and that death occurred at <u>6 P.M.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Charles W. Weekes M.D.</u>				23b. ADDRESS <u>2316 Marked</u>			23c. DATE SIGNED <u>2-15-51</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>2-17-51</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Washington Park</u>		24d. LOCATION (City, town, or county) <u>St. Louis County, Mo.</u>		(State) _____	
DATE REC'D BY LOCAL REG. <u>FEB 15 1951</u>		REGISTRAR'S SIGNATURE <u>J.P. Koster</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>Dement &amp; Son</u> ADDRESS <u>2629-31 Cole St.</u>				

(Licensed Embalmer's Statement on Reverse Side)

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 *H. Claude Gordon*

Licensed Embalmer No. *3489*

P. O. Address *4575 Alder*

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.