

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6732**
Registrar's No. **1071**

FILED FEB 16 1951

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE	
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) OR TOWN BROOKLYN	
c. LENGTH OF STAY (in this place) 3 DAYS		d. STREET ADDRESS (If rural, give location) 401 South 3rd Street	
d. FULL NAME OF HOSPITAL OR INSTITUTION Peoples Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) BARBARA	b. (Middle) JEAN	c. (Last) TRICE	4. DATE OF DEATH (Month) (Day) (Year) FEB. 1, 1951
5. SEX Female	6. COLOR OR RACE negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH OCT 3, 1934
9. AGE (In years last birthday) 16	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK	10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (State or foreign country) BROOKLYN, ILLINOIS	12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME EZELL TRICE	13b. MOTHER'S MAIDEN NAME ALMETA JEFFERSON	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 AND ADDRESS EZELL TRICE 202 So. 3rd St. Lovejoy, ILLINOIS

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		INTERVAL BETWEEN ONSET AND DEATH 7 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Stitic Meningitis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 39120

22. I hereby certify that I attended the deceased from **1-25**, 1951, to **2-1**, 1951, that I last saw the deceased alive on **Feb 1, 1951**, and that death occurred at **5 a. m.**, from the causes and on the date stated above.

23a. SIGNATURE D. Carl Williams M.D.	(Degree or title)	23b. ADDRESS 301 South 3rd St. Lovejoy, Ill.	23c. DATE SIGNED FEB 2 1951
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE FEB 3 1951	24c. NAME OF CEMETERY OR CREMATORY EAST ST. LOUIS	24d. LOCATION (City, town, or county) (State) ILL.

DATE REC'D BY LOCAL REG. FEB 2 1951	REGISTRAR'S SIGNATURE J. B. Lasater	25. FUNERAL DIRECTOR'S SIGNATURE J. L. Marshall	ADDRESS E. ST. LOUIS, ILL.
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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 Thomas M. Habson

Licensed Embalmer No. 4479

P. O. Address ST. LOUIS, MO.

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.