

FILED MAR 29 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 10525
2432

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1000		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (When deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis		c. LENGTH OF STAY (in this place) 8 years		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis		2219	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital				d. STREET ADDRESS (If rural, give location) 1813 Cole St			
3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) _____ c. (Last) Pye			4. DATE OF DEATH March 12 1951				
5. SEX Female 3	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH May 3, 1890		9. AGE (In years last birthday) 60	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 60 Hrs. _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) Arkansas		12. CITIZEN OF WHAT COUNTRY? U S A	
13a. FATHER'S NAME Jack Washington		13b. MOTHER'S MAIDEN NAME France Holmes		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Jack Washington S Kirkwood Park MO			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Arteriosclerosis ANTECEDENT CAUSES DUE TO (b) Undetermined DUE TO (c) _____ Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None				INTERVAL BETWEEN ONSET AND DEATH Undet.	
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? 4500			
22. I hereby certify that I attended the deceased from 3-8, 1951, to 3-12, 1951, that I last saw the deceased alive on 3-12, 1951, and that death occurred at 3:50 p.m., from the causes and on the date stated above.							
23. SIGNATURE M. D. (Degree or title) M. D.				23b. ADDRESS 2601 N Whittier St		23c. DATE SIGNED 3-14-51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3/17/51	24c. NAME OF CEMETERY OR CREMATORY Washington Park		24d. LOCATION (City, town, or county) St. Louis, Mo		(State) MO
DATE REC'D BY LOCAL REG. MAR 15 1951		REGISTRAR'S SIGNATURE J B Foster		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Boyd Bros., 3706 Finney Ave			

(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

Edward A. Flynn

Licensed Embalmer No.

4444

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.

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