

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUN. 23 1951

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State File No. 21188
5412

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 Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) Unknown	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2219 STREET ADDRESS 3013 Laclede 8	
3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) c. (Last) Crow			4. DATE OF DEATH (Month) (Day) (Year) June 3 1951
5. SEX 3 Female	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Sep.	8. DATE OF BIRTH Sept. 2, 1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years last birthday) 49 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) Ill.		12. CITIZEN OF WHAT COUNTRY? U S A	
13a. FATHER'S NAME Dennis Hay		13b. MOTHER'S MAIDEN NAME Minerva Robinson	14. NAME OF HUSBAND OR WIFE Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Elizabeth Rhodes, 2601 N Whittier St ADDRESS

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Undet.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Undetermined 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"/>
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? H200

22. I hereby certify that I attended the deceased from 3-15, 19 51, to 6-3, 19 51, that I last saw the deceased alive on 6-3, 19 51, and that death occurred at 3:05a m., from the causes and on the date stated above.

23a. SIGNATURE Clarice M. Turner, D. (Degree or title)	23b. ADDRESS 2601 N Whittier St.	23c. DATE SIGNED 6-7-51
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE JUN 14 1951	24c. NAME OF CEMETERY OR CREMATORY Anatomical Bldg
24d. LOCATION (City, town, or county) (State)		

DATE REC'D BY LOCAL REG. JUN 14 1951	REGISTRAR'S SIGNATURE J. B. Foster	25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service Inc	ADDRESS 4104 Manchester Ave. St. Louis 10, M
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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 _____

Students of Mortuary College

working under my personal supervision.

Student Embalmer No.

Signed _____

James A. Lammere

Signed.....
Student Embalmer

Licensed Embalmer No. *4142*

P. O. Address *St Louis*

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.