

FILED AUG. 25 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 28839

7241

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1002</b>		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY <b>0</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b>				b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		<b>2189</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Homer G. Phillips Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>3344 A Laeledge</b>				<b>0</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>George</b>		b. (Middle) _____		c. (Last) <b>Washington</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>8 11 51</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Nov. 9, 1891</b>		9. AGE (In years last birthday) <b>59</b>	IF UNDER 1 YEAR Months <b>9</b> Days <b>2</b>	IF UNDER 2 HRS. Hours _____ Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WATCHMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Atco Wrecking Co</b>		11. BIRTHPLACE (State or foreign country) <b>Atlanta, Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13a. FATHER'S NAME <b>Jake Washington</b>		13b. MOTHER'S MAIDEN NAME <b>Anna unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Orleana Washington</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No None</b>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Orleana Washington 3344 Laeledge</b>					
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.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pulmonary Tuberculosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>			
		ANTECEDENT CAUSES DUE TO (b) <b>Undetermined</b>							
		DUE TO (c) <b>Undet.</b>							
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>None</b>							
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? <b>PO 2X</b>					
22. I hereby certify that I attended the deceased from <b>8-8-51</b> , 19____, to <b>8-11-51</b> , 19____, that I last saw the deceased alive on <b>8-11-51</b> , 19____, and that death occurred at <b>8:15 pm.</b> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <b>James W. Harris, M. D.</b>				23b. ADDRESS <b>2601 N. Whittier Street</b>		23c. DATE SIGNED <b>8-13-51</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>8-16-51</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo</b>				
DATE REC'D BY LOCAL REG. <b>AUG 14 1951</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Bennie Love 3103 Washington</b>					

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 Co. \_\_\_\_\_

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.