No. 300
10-48

FILED OCT 10 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31695

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8404

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis
c. LENGTH OF STAY (In this place): 10-Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2930 Montgomery

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 20 St Louis 2209
d. STREET ADDRESS (If rural, give location): 2930 Montgomery

3. NAME OF DECEASED (Type or Print)
a. (First): Susie
b. (Middle):
c. (Last): Maxey

4. DATE OF DEATH (Month) (Day) (Year): Sept 20 1951

5. SEX: Female 2
6. COLOR OR RACE: Colored
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Wid. 2
8. DATE OF BIRTH: Sept. 15-1889
9. AGE (In years last birthday): 62 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Jackson Miss
12. CITIZEN OF WHAT COUNTRY? U S A

13a. FATHER'S NAME: Frank Mason
13b. MOTHER'S MAIDEN NAME: Unknown
14. NAME OF HUSBAND OR WIFE: None

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: No
17. INFORMANT'S SIGNATURE OR NAME: James Boley 2930 Montgomery 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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Degeneration — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Mitral Heart Disease — ?
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 ☐ NO ☐

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? NOX

22. *I hereby certify that I attended the deceased from* 9-7, 1951, *to* 9-20, 1951, *that I last saw the deceased alive on* 9-20, 1951, *and that death occurred at* 10 40 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE: J. C. Sherard, M.D. (Degree or title)
23b. ADDRESS: 2702a Franklin
23c. DATE SIGNED: 9-21-51

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept 25- 51
24c. NAME OF CEMETERY OR CREMATORY: Washington Park
24d. LOCATION (City, town, or county) (State): St Louis County MO

DATE REC'D BY LOCAL REG.: SEP 22 1951
REGISTRAR'S SIGNATURE: J. Earl Smith M.D.
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Boyd Bros 3706 Finney Ave

(Licensed Embalmer's Statement on Reverse Side)

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.....

.....,

working under my personal supervision.

Student Embalmer No.....

Signed Henry C. Williams

Signed.....
Student Embalmer

Licensed Embalmer No. 4781

P. O. Address 1205 Walton A

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.