

FILED OCT 23 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35527**
Registrar's No. **8844**

318

1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. 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. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2119	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 4574 Cotebrillante ave	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Samantha	b. (Middle)	c. (Last) Raze	(Month) Oct	(Day) 3	(Year) 1951
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 23rd 1900	9. AGE (In years last birthday) 51	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Greenville Texas		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Champ Marrell	13b. MOTHER'S MAIDEN NAME Elizabeth Cozine	14. NAME OF HUSBAND OR WIFE Edward Raze
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 Edward Raze ADDRESS 4574 Cotebrillante ave

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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 6 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		
	ANTECEDENT CAUSES DUE TO (b) Hypertensive Heart Disease Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) Undet.		
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 443X	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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-27, 1951, to 10-3, 1951, that I last saw the deceased alive on 10-3, 1951, and that death occurred at 3:15a m., from the causes and on the date stated above.

23a. SIGNATURE L. Arlen Harris M.D. (Degree or title)	23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 10--3-51
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 10/8/51	24c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery
DATE REC'D BY LOCAL REG. OCT 6 1951		24d. LOCATION (City, town, or county) (State) St Louis County
REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. W. Roberts 1416 N. Taylor ave

WRITE PLAINLY—USING UNFAADING 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 Eustace E. Culkin

Licensed Embalmer No. 4198

P. O. Address Albany 13

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.