

FILED DEC 1 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 38719
10425

BIRTH NO. _____		REG. DIST. NO. 318	PRIMARY REG. DIST. 1003	Registrar's No. _____
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO. b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis MO.		c. LENGTH OF STAY (In this place) 2 1/2 yr		
c. CITY (If outside corporate limits, write RURAL and give township) St. Louis		d. STREET ADDRESS (If rural, give location) 912 Riddle		
d. FULL NAME OF HOSPITAL OR INSTITUTION Hosp 2				
3. NAME OF DECEASED (Type or Print) a. (First) Kessie		b. (Middle)		c. (Last) Black
4. DATE OF DEATH (Month) (Day) (Year) Nov 19-1951				
5. SEX 3	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W	8. DATE OF BIRTH May 4-1920	9. AGE (In years last birthday) 31
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Jackson - Miss.
12. CITIZEN OF WHAT COUNTRY USA				
13a. FATHER'S NAME Martin Bermon		13b. MOTHER'S MAIDEN NAME Amanda Nixon		14. NAME OF HUSBAND OR WIFE John A Black
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war, or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Joseph German
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Apoplexy 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 checked="" type="checkbox"/> NO <input 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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 324X
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 1230 P.M. , from the causes and on the date stated above.				
23a. SIGNATURE Patrick E. Taylor, M.D.		23b. ADDRESS 1305 Clark		23c. DATE SIGNED 11-23-51
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE Nov. 23-1951		24c. NAME OF CEMETERY OR CREMATORY Douglas
24d. LOCATION (City, town, or county) (State) St. Louis Co. - E. St. Louis Mo.				
DATE REC'D BY LOCAL REGISTRY Nov 23 1951		REGISTRAR'S SIGNATURE J. E. Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Mrs. A. V. Officer
				ADDRESS 214 1/2 W. 1st

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 Student Embalmer No.
working under my personal supervision.

Student
Student Embalmer

Signed *James G. Lemmers*

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.