

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43004

State File No.

FILED JAN 10 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10839**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY 2117	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	c. LENGTH OF STAY (in this place) 9 yrs	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 11 4246 W Evans	

3. NAME OF DECEASED (Type or Print) a. (First) Jannie b. (Middle) Hearn c. (Last) Hearn			4. DATE OF DEATH (Month) (Day) (Year) Dec. 1 1951			
5. SEX Female 3	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow 2)	8. DATE OF BIRTH Aug. 10, 1872	9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Months Days	IF UNDER 1 YEAR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kentucky 1		12. CITIZEN OF WHAT COUNTRY? U S A

13a. FATHER'S NAME Dan Lawrie	13b. MOTHER'S MAIDEN NAME Adeline Thomas	14. NAME OF HUSBAND OR WIFE
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 Eva Scott 6705
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		ADDRESS

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Arteriosclerotic Disease		Undetermined		Undet.
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR H

22. I hereby certify that I attended the deceased from **7-21**, 19 **51**, to **12-1**, 19 **51**, that I last saw the deceased alive on **12-1**, 19 **51**, and that death occurred at **7:50p. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) L. Green M. D.	23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 12-3-51
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE Dec 8, 1951	24c. NAME OF CEMETERY OR CREMATORY Washington Park Cem
DATE REC'D BY LOCAL REG. DEC 6 1951	REGISTRAR'S SIGNATURE Carl Smith MD	24d. LOCATION (City, town, or county) (State) St Louis MO
25. FUNERAL DIRECTOR'S SIGNATURE F. L. Green		ADDRESS 4217 Delmar

mrb (Licensed Embalmer's Statement on Reverse Side)

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 No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Eugene Miles

Licensed Embalmer No. 3623

P. O. Address 4214 Delmar

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.