

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6293**

FILED MAR 5 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1361**

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. LENGTH OF STAY (in this place) 2 yrs.		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) 4241 West Finney Avenue					
3. NAME OF DECEASED (Type or Print) a. (First) Susie		b. (Middle) Mae		c. (Last) Chambers			
4. DATE OF DEATH (Month) (Day) (Year) Feb. 11 1952		5. SEX Female 3		6. COLOR OR RACE Negro			
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH Jan. 15, 1918		9. AGE (In years last birthday) 34			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry Work		10b. KIND OF BUSINESS OR INDUSTRY Laundry		11. BIRTHPLACE (State or foreign country) Drew, Mississippi			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Harvey Williams		13b. MOTHER'S MAIDEN NAME Jessie Miller			
14. NAME OF HUSBAND OR WIFE Wiley Chambers		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 Jimmv Williams (Bro.)		ADDRESS 4241 W. Finney					
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) Thyrototoxicosis DUPLICATE (b) Undetermined DUPLICATE (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None				INTERVAL BETWEEN ONSET AND DEATH Undet.	
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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21h. HOW DID INJURY OCCUR? 252.0			
22. I hereby certify that I attended the deceased from 2-7 , 19 52 , to 2-11 , 19 52 , that I last saw the deceased alive on 2-11 , 19 52 , and that death occurred at 9:15a m., from the causes and on the date stated above.							
23a. SIGNATURE Wm. J. Reid (Degree or title) M. D.		23b. ADDRESS 2601 N Whittier St		23c. DATE SIGNED 2-11-52			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 5		24b. DATE 2/13/52		24c. NAME OF CEMETERY OR CREMATORY Shelby, Mississippi			
24d. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR'S SIGNATURE GATES FUNERAL HOME ADDRESS Charles J. Gates. 4107 Finney Ave.					
DATE REC'D BY LOCAL REG. FEB 13 1952		REGISTRAR'S SIGNATURE Carl Smith, M.D. (Licensed Embalmer's Statement on Reverse Side)					

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

STATEMENT BY LICENSED EMBALMER

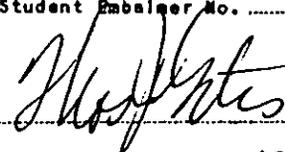
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

.....
working under my personal supervision.

Student Embalmer No. _____

Student
Student Embalmer

Signed _____



Licensed Embalmer No. 4259

P. O. Address 4107 Finney Avenue

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.