

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6616**
Registrar's No. **1322**

FILED MAR 5 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE				b. COUNTY																			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.				c. LENGTH OF STAY (In this place)				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis																			
d. FULL NAME OF HOSPITAL OR INSTITUTION DOA Homer Phillips Hospital				d. STREET ADDRESS (If rural, give location) 2903a Dickson Street																							
3. NAME OF DECEASED (Type or Print) Red				a. (First)				b. (Middle)				c. (Last)				4. DATE OF DEATH (Month) (Day) (Year) Feb 7 1952											
5. SEX Male				6. COLOR OR RACE Col				7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married				8. DATE OF BIRTH April 9 1898				9. AGE (In years last birthday) 52				IF UNDER 1 YEAR Months 9 Days 28				IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Cotton Plant Ark				12. CITIZEN OF WHAT COUNTRY? U.S.A.															
13a. FATHER'S NAME Wash Mayo				13b. MOTHER'S MAIDEN NAME Josephine				14. NAME OF HUSBAND OR WIFE Tecora Mayo																			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes W.W. # 1				16. SOCIAL SECURITY NO.				17. INFORMANT'S SIGNATURE OR NAME Tecora Mayo 2903a Dickson St				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, 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) Pautice Hemorrhage DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.								INTERVAL BETWEEN ONSET AND 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 321X																			
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 5:57 p. m., from the causes and on the date stated above.																											
23a. SIGNATURE W. H. Randle				(Degree or title)				23b. ADDRESS 1300 Clark Avenue				23c. DATE SIGNED 2/8/52															
24a. BURIAL, CREMATION, REMOVAL (Specify)				24b. DATE 2-13-52				24c. NAME OF CEMETERY OR CREMATORY National				24d. LOCATION (City, town, or county) (State) Jefferson Brks, Co. Mo.															
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE FEB 11 1952 Carl Smith MO				25. FUNERAL DIRECTOR'S SIGNATURE J.H. Randle & Son 3133 Bell Avenue				ADDRESS																			

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

STATEMENT BY LICENSED EMBALMER

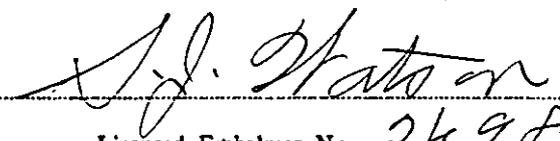
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed.....



Licensed Embalmer No. 2698

P. O. Address 2769 Chautauque

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.