

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10087

State File No.

FILED MAR 24 1952

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2162

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 2219

d. FULL NAME OF HOSPITAL OR INSTITUTION: Homer G Phillips Hospital

d. STREET ADDRESS (If rural, give location) 21 2714 Mills

3. NAME OF DECEASED (Type or Print)
a. (First) Florence b. (Middle) _____ c. (Last) Hill

4. DATE OF DEATH (Month) (Day) (Year)
Mar. 1 1952

5. SEX 3
F

6. COLOR OR RACE
Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
Married

8. DATE OF BIRTH
Sept. 11, 1910

9. AGE (In years last birthday) 41
IF UNDER 1 YEAR Months _____ Days _____
IF UNDER 24 HRS. Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None

10b. KIND OF BUSINESS OR INDUSTRY
None

11. BIRTHPLACE (State or foreign country) St. Louis, Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME
Lewis Moore

13b. MOTHER'S MAIDEN NAME
Unknown

14. NAME OF HUSBAND OR WIFE
Sam Hill

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.
500-16-6872

17. INFORMANT'S SIGNATURE OR NAME ADDRESS
Lucille Hoyer 2714 Mills

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
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Far Advanced Pulmonary Tuberculosis
INTERVAL BETWEEN ONSET AND DEATH Undet.

ANTECEDENT CAUSES
DUE TO (b) Undetermined
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES NO

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 NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? 002X

22. I hereby certify that I attended the deceased from 12-27, 1951, to 3-1, 1952, that I last saw the deceased alive on 3-1, 1952, and that death occurred at 10:20am., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)
Lorena Wharris M. D.

23b. ADDRESS
2601 N Whittier St

23c. DATE SIGNED
3-3-52

24a. BURIAL, CREMATION, REMOVAL (Specify)
Removal 4

24b. DATE
3-7-52

24c. NAME OF CEMETERY OR CREMATORY
Washington Park

24d. LOCATION (City, town, or county) (State)
St. Louis County Mo.

DATE REC'D BY LOCAL REG.
MAR 6 1952

REGISTRAR'S SIGNATURE
Carl Smith md

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
EB Rance 1221 N. Grand

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

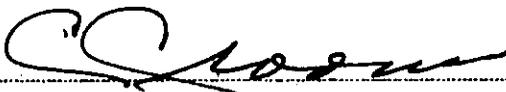
STATEMENT BY LICENSED EMBALMER

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. 4755

P. O. Address 12277 Egan

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.