

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **10783**

Registrar's No. **1991**

FILED MAR 24 1952

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

1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		2. USUAL RESIDENCE (Where deceased lived. -If institution: residence before admission). a. STATE Missouri b. COUNTY _____ c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2189 d. STREET ADDRESS (If rural, give location) 0 18 2012 Laclede Avenue	
3. NAME OF DECEASED (Type or Print) Surviller a. (First) _____ b. (Middle) _____ c. (Last) Woodfork		4. DATE OF DEATH (Month) (Day) (Year) Feb. 27 1952	
5. SEX Female 3	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 9	8. DATE OF BIRTH Feb. 7, 1896 9. AGE (In years last birthday) X 56 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 100 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) Arkansas Patamos		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME West Wilson		13b. MOTHER'S MAIDEN NAME Janie Hoskins	
14. NAME OF HUSBAND OR WIFE nil		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 ADDRESS John Mullen, 2912 Laclede	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Adeno Carcinoma of Ovary ANTECEDENT CAUSES DUE TO (b) Undetermined 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 type="checkbox"/> NO <input checked="" type="checkbox"/>		21. ACCIDENT SUICIDE HOMICIDE (Specify) _____	
21a. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21b. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____	
21c. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) _____		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. HOW DID INJURY OCCUR? 175X		22. I hereby certify that I attended the deceased from 2-23- 19 52 to 2-27 19 52 , that I last saw the deceased alive on 2-27 19 52 , and that death occurred at 8:10p m. , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) Charles M. Turner M. D.		23b. ADDRESS 2601 N Whittier St.	
23c. DATE SIGNED 2-29-52		24a. BURIAL, CREMATION, REMOVAL (Specify) burial	
24b. DATE 3-3-52		24c. NAME OF CEMETERY OR CREMATORY Washington Park	
24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Dement & Son 2629-31 Cole St.	
DATE REC'D BY LOCAL REG. MAR 3 1952		REGISTRAR'S SIGNATURE Carl Smith MD	

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10-48

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 Arthur P. Hilliard

Licensed Embalmer No. 4221

P. O. Address 4524 Aldine

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.