

FILED APR 25 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 14412
3049

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE			
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis MO				c. CITY (If outside corporate limits, write RURAL and give township) St. Louis MO. 22/9			
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital				d. STREET ADDRESS (If rural, give location) 21 2311 Delmar Blvd			
3. NAME OF DECEASED (Type or Print)		a. (First)		b. (Middle)		c. (Last)	
Claudie		Hill		James		4. DATE OF DEATH (Month) (Day) (Year) March 29 1952	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Dec 25		9. AGE (In years last birthday) About 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nursekeeper		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME not known		13b. MOTHER'S MAIDEN NAME Hannie Jackson		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) no		16. SOCIAL SECURITY NO. no		17. INFORMANT'S SIGNATURE OR NAME Hannie James Missou 818 N 18th St			
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) Generalized Arteriosclerosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) sarcoidosis? DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Malnutrition; Calcified Uterine Myoma				INTERVAL BETWEEN ONSET AND DEATH	
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) m.		21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒		21f. HOW DID INJURY OCCUR? 4500			
22. I hereby certify that I attended the deceased from 3-24, 1952, to 3-29, 1952, that I last saw the deceased alive on 3-29, 1952, and that death occurred at 10:05 a.m., from the causes and on the date stated above.							
23. SIGNATURE L. Harris M.D.				23b. ADDRESS 2601 N Whittier St.		23c. DATE SIGNED 3-31-52	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 4-1-52		24c. NAME OF CEMETERY OR CREMATORY Oakdale Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis MO	
DATE REC'D BY LOCAL REG. APR 1 1952		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE A. B. Best Und Co 4303 Delmar			

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.

Leroy Bannister

Student
Student Embalmer

Signed *4523*

Licensed Embalmer No. _____

P. O. Address _____

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.