

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
318

State File No. 18030
Registrar's No. 4094

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		State File No. 18030		Registrar's No. 4094		
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)		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 3523a Lawton Ave.						
3. NAME OF DECEASED (Type or Print) a. (First) Sallie			b. (Middle) Glenn			c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) April 27 1952	
5. SEX 3 Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 3		8. DATE OF BIRTH 8-14-1873		9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nil (maid)			10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (City and State or Foreign Country) West Point, Ga.			12. CITIZEN OF WHAT COUNTRY? USA		
13a. FATHER'S NAME William Collins			13b. MOTHER'S MAIDEN NAME Unknown			14. NAME OF HUSBAND OR WIFE Albert Glenn				
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. 491-18-1021-A		17. INFORMANT'S SIGNATURE OR NAME ADDRESS LaDorris Buford, 3523a Lawton					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)										
<p style="text-align: center;">MEDICAL CERTIFICATION</p> <p>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Partial Intestinal Obstruction</u></p> <p>INTERVAL BETWEEN ONSET AND DEATH <u>Undet.</u></p> <p>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</p> <p>ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Metastasis from Carcinoma of Uterus</u></p> <p>DUE TO (c)</p> <p>II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u></p>										
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) (Minute)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21f. HOW DID INJURY OCCUR? 174X					
22. I hereby certify that I attended the deceased from <u>4-24</u> , 19 <u>52</u> , to <u>4-27</u> , 19 <u>52</u> , that I last saw the deceased alive on <u>4-27</u> , 19 <u>52</u> , and that death occurred at <u>11:59^a</u> m., from the causes and on the date stated above.										
23a. SIGNATURE <i>Wm H Reid</i> M. D.				23b. ADDRESS 2601 N Whittier St				23c. DATE SIGNED 4-29-52		
24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 5-3-52		24c. NAME OF CEMETERY OR CREMATORY Father Dickson		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.				
DATE REC'D BY LOCAL REG. MAY 1 1952		REGISTRAR'S SIGNATURE <i>J. Carl Smith</i> mbs				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Russell Und., Co. 2732 Pine Blvd.				

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

James A. Carter

Licensed Embalmer No. *4681*

P. O. Address *4923 Suburban*

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.