

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36447**
Registrar's No. **9920**

FILED NOV 13 1952

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

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS 4447 Elmbank	
3. NAME OF DECEASED a. (First) Della (Type or Print)		c. (Last) Hart	
b. (Middle)		4. DATE OF DEATH (Month) (Day) (Year) Oct. 27 1952	
5. SEX Female		6. COLOR OR RACE Colored	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH Sept 16-1889	
9. AGE (In years last birthday) 72		10. IF UNDER 1 YEAR: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (City and State or Foreign Country) Tenn.		12. CITIZEN OF WHAT COUNTRY? U S A	
13a. FATHER'S NAME Ozra Tillman		13b. MOTHER'S MAIDEN NAME Nannie Whiteside	
14. NAME OF HUSBAND OR WIFE DEAD			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT'S SIGNATURE OR NAME Lulu Millinder		ADDRESS 4447 Elmbank	
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) Severe Malnutrition (014-711) ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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. Undet.	
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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 2865			
22. I hereby certify that I attended the deceased from 10-25 , 19 52 to 10-27 , 19 52 , that I last saw the deceased alive on 10-27 , 19 52 , and that death occurred at 4:40a m., from the causes and on the date stated above.			
23a. SIGNATURE Wm. E. Jensen (Degree or title) M. D.		23b. ADDRESS 2601 N Whittier St	
23c. DATE SIGNED 10-28-52			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 10/31/52	
24c. NAME OF CEMETERY OR CREMATORY ST PETERS CEMETERY		24d. LOCATION (City, town, or county) (State) ST LOUIS COUNTY	
DATE REC'D BY LOCAL REG. OCT 28 1952		25. FUNERAL DIRECTOR'S SIGNATURE W. Roberts ADDRESS 1416 N Taylor Ave	

mfb. (Licensed Embalmer's Statement on Reverse Side)

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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 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.