S. No. 300
v. 10-48

FILED NOV 13 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37020

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 10009

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1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2719 Bernard St

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis, Mo. 2229
d. STREET ADDRESS (If rural, give location): 2719 Bernard St

3. NAME OF DECEASED (Type or Print)
a. (First): Mary
b. (Middle): Lou
c. (Last): Windom

4. DATE OF DEATH (Month) (Day) (Year): 10-25-52

5. SEX: Female 3
6. COLOR OR RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: July 18, 1882
9. AGE (In years last birthday): 70 — 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): Nil
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (City and State or Foreign Country): Huntsville Ala
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME: John Davis
13b. MOTHER'S MAIDEN NAME: Sarah Pope
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)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME — ADDRESS: John H. Windom, 4816 Hammett Pl.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma Liver — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Gastro-Enteritis — ?
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: None
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? 155X

22. *I hereby certify that I attended the deceased from* 7/14, 1952, *to* 10/25, 1952, *that I last saw the deceased alive on* 10/25, 1952, *and that death occurred at* 10A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): D. E. G. Taylor MD
23b. ADDRESS: 3136 Chautauqua
23c. DATE SIGNED: 10/29/52

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: Nov 1, 1952
24c. NAME OF CEMETERY OR CREMATORY: St. Peters
24d. LOCATION (City, town, or county) (State): St. Louis County Mo

DATE REC'D BY LOCAL REG.: OCT 31 1952
REGISTRAR'S SIGNATURE: J. Carl Smith MD
25. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Bennie Love 3103 Washington

(Licensed Embalmer's Statement on Reverse Side)

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

Dave Primary side

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 W. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 4575 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.