

No. 300
10.48

FILED DEC 2 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40159**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10400**

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. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SAINT LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If rural, give location) 4261 A. E. MAFFITT	

3. NAME OF DECEASED (Type or Print) a. (First) VIOLA b. (Middle) - c. (Last) ELLIS			4. DATE OF DEATH (Month) (Day) (Year) 11 - 9 - 52		
5. SEX FEMALE 3		6. COLOR OR RACE NEGRO		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	
8. DATE OF BIRTH AUGUST 19, 1907		9. AGE (In years last birthday) 45		10. IF UNDER 1 YEAR Days 2 IF UNDER 1 Mth. Hours 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HONE		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11. BIRTHPLACE (City and State or Foreign Country) MACON, MISSISSIPPI	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME SAM TRIPLETT		13b. MOTHER'S MAIDEN NAME MARINDA SHERROD		14. NAME OF HUSBAND OR WIFE ANDREW ELLIS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, state year or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME ADDRESS ANDREW ELLIS 4261 A. E. MAFFITT	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH 2 days
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident		DUE TO (b) Hypertension			
*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		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"/>	
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 331X		

22. I hereby certify that I attended the deceased from **10-16-**, 1952, to **11-9-**, 1952, that I last saw the deceased alive on **11-9-**, 1952, and that death occurred at **10:21pm.**, from the causes and on the date stated above.

23a. SIGNATURE <i>W. D. Vermillion, M.D.</i> (Degree or title) M.D.		23b. ADDRESS BARNES HOSPITAL		23c. DATE SIGNED 11-9-52	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE NOV. 13, 1952		24c. NAME OF CEMETERY OR CREMATORY WASHINGTON PARK CEMETERY	
24d. LOCATION (City, town, or county) (State) SAINT LOUIS, COUNTY, MISSOURI					

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE NOV 12 1952 <i>J. Earl Smith, M.D.</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>W. D. Keane</i> 1221 N. GRAND BLVD.	
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G.P. (Licensed Embalmer's Statement on Reverse Side)

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 Winton H. Swan
Licensed Embalmer No. 4580

P. O. Address 1221st Grand

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.