

0.300  
0.48

FILED DEC 2 1952

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 40196

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 10480

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u> <u>2219</u>	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) <u>21 2122 Chestnut 0</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Homer G. Phillips</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Gertrude</u> b. (Middle) <u>Flukers</u> c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 10 1952</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Dec. 9, 1949</u>
9. AGE (In years last birthday) <u>2</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Arkansas</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME <u>Earnest Flukers</u>	13b. MOTHER'S MAIDEN NAME <u>Posie Young</u>	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) <u>NO</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Posie Young - 2122 Chestnut</u>	

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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

ANTECEDENT CAUSES

DUE TO (b) Meningococcus

DUE TO (c) Meningitis

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? <u>0570</u>

22. I hereby certify that I attended the deceased from \_\_\_\_\_, 1952, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at 12:12 m., from the causes and on the date stated above.

23a. SIGNATURE (Deputy or title) <u>Bluk E Taylor (Deputy)</u>	23b. ADDRESS <u>1301 Park</u>	23c. DATE SIGNED <u>11/13/52</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>Nov. 13, 1952</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Marianna, Ark.</u>
24d. LOCATION (City, town, or county) (State) <u>Ark.</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W. English Und. Co. - 1123 N. Taylor</u>	

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

*John K. Cunningham*

Licensed Embalmer No. *4470*

P. O. Address *1123 N. Taylor*

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.