

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3350**
REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **0236**

FILED JAN 28 1953

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 St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 911 N Garrison	
3. NAME OF DECEASED (Type or Print) a. (First) Amanda b. (Middle) c. (Last) King		4. DATE OF DEATH (Month) (Day) (Year) Jan. 7 1953	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Jan. 26, 1872
9. AGE (In years last birthday) 80		10. MONTHS 11	11. DAYS 11
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME John Willard		13b. MOTHER'S MAIDEN NAME Emma (Unknown)	
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) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME William H. King	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		19. ADDRESS 4210 W. Garfield Ave.	
MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure		INTERVAL BETWEEN ONSET AND DEATH Undet.	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease		"	
DUE TO (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None			
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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR 4200			
22. I hereby certify that I attended the deceased from 12-17 , 19 52 , to 1-7 , 19 53 , that I last saw the deceased alive on 1-7 , 19 53 , and that death occurred at 1:35a m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Charles P. Ford M. D.		23b. ADDRESS 2601 N. Whittier St.	
23c. DATE SIGNED 1-8-53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Jan. 10, 1953	
24c. NAME OF CEMETERY OR CREMATORY St. Peter's		24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.	
DATE REC'D BY LOCAL REG. JAN 9 1953		25. FUNERAL DIRECTOR'S SIGNATURE J. H. Randle & Son	
REGISTRAR'S SIGNATURE J. Carl Smith MD		ADDRESS 3133 Bell Ave.	

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 *J. J. Watson*

Licensed Embalmer No. *269 J*

P. O. Address *2769 Chouteau*

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.