

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **3896**

FILED FEB 11 1953

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

Registrar's No. **0775**

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) 4762 Cote Brilliante	
3. NAME OF DECEASED (Type or Print) a. (First) Eva b. (Middle) Mae c. (Last) Ward			4. DATE OF DEATH (Month) (Day) (Year) Jan. 21 1953
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 4, 1918
9. AGE (In years last birthday) 34		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME Sylvester Gaines	
13b. MOTHER'S MAIDEN NAME Bettie Talbert		14. NAME OF HUSBAND OR WIFE Simon Ward	
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.	17. INFORMANT'S SIGNATURE OR NAME Simon Ward
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) Cerebral Anoxia INTERVAL BETWEEN ONSET AND DEATH 25 hours	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c)		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Thyrotoxicosis	
19a. DATE OF OPERATION 1-20-53		19b. MAJOR FINDINGS OF OPERATION Cardiac Standstill, Temporary	
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? 5272		22. I hereby certify that I attended the deceased from 11-19 , 19 52 to 1-21- , 19 53 that I last saw the deceased alive on 1-21 , 19 53 , and that death occurred at 8:45 Pm. , from the causes and on the date stated above.	
23a. SIGNATURE Carl S. Rollins		23b. ADDRESS 2601 N Whittier St	
23c. DATE SIGNED 1-28-53		24a. BURIAL, CREMATION, REMOVAL (Specify) removal	
24b. DATE 1-27-53		24c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.		25. FUNERAL DIRECTOR'S SIGNATURE A.F. Walton	
DATE REC'D BY LOCAL REG. 1-23-53		REGISTRAR'S SIGNATURE J. Carl Smith	
25. FUNERAL DIRECTOR'S SIGNATURE A.F. Walton		ADDRESS 2707 Stoddard St.	

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 *Arthur L. Heilbard*

Licensed Embalmer No. *4224*

P. O. Address *4524 Alden*

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.