No. 300
10.48

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7793

State File No. 1654

FILED FEB 26 1953

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1654

1. PLACE OF DEATH
a. COUNTY ~~1002a Mound Street~~
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis
c. LENGTH OF STAY (In this place) 20 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis 2269
d. STREET ADDRESS (If rural, give location) 26 1002a Mound Street

3. NAME OF DECEASED (Type or Print)
a. (First) Lucinda
b. (Middle)
c. (Last) Miller

4. DATE OF DEATH (Month) Feb. (Day) 9, (Year) 1953

5. SEX Female 3

6. COLOR OR RACE Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widow

8. DATE OF BIRTH July 31, 1885

9. AGE (In years last birthday) 67 — 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) unemployed

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and State or Foreign Country) Cape Girardeau, Mo.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Joseph Bollinger

13b. MOTHER'S MAIDEN NAME L r (unknown)

14. NAME OF HUSBAND OR WIFE nil

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S SIGNATURE OR NAME Dora Richards **ADDRESS** 1205a S. Jefferson Av

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) Mitral insufficiency

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.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

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? 410X

22. *I hereby certify that I attended the deceased from* 1-26, 1953, *to* 2-9, 1953 *that I last saw the deceased alive on* 2-9, 1953, *and that death occurred at* 7:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE H W Wilkerson (Degree or title) MD

23b. ADDRESS 4141 Page

23c. DATE SIGNED 2-12-53

24a. BURIAL, CREMATION, REMOVAL (Specify) removal

24b. DATE 2-13-53

24c. NAME OF CEMETERY OR CREMATORY Greenwood

24d. LOCATION (City, town, or county) St. Louis County, (State) Mo.

DATE REC'D BY LOCAL REG. FEB 13 1953

REGISTRAR'S SIGNATURE Earl Smith MD

25. FUNERAL DIRECTOR'S SIGNATURE DeMent & Son **ADDRESS** 2629-31 Cole Street

(Licensed Embalmer's Statement on Reverse 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 _____ Signed W. Claude Gordon

Student Embalmer

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.