

STANDARD CERTIFICATE OF DEATH

7830

State File No. 7830
Registrar's No. 1640

FILED FEB 26 1953

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

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 St. Louis 2229	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 22 2328 Clark	
3. NAME OF DECEASED (Type or Print) Emma		4. DATE OF DEATH (Month) (Day) (Year) Parish Feb. 8 1953	
5. SEX Female		6. COLOR OR RACE negro	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH Feb? 1874	
9. AGE (In years last birthday) 78		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (City and State or Foreign Country) Louisiana		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Bob Taylor		13b. MOTHER'S MAIDEN NAME Winie Mills	
14. NAME OF HUSBAND OR WIFE Parish		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Florence Wade - 327d. Cwing	
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) Carcinoma of Cervix ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Undetermined 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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 171X		22. I hereby certify that I attended the deceased from 1-14 , 19 53 , to 2-8 , 19 53 , that I last saw the deceased alive on 2-8 , 19 53 , and that death occurred at 12:01 a.m. , from the causes and on the date stated above.	
23a. SIGNATURE N. Alan Harris (Degree or title) M. D.		23b. ADDRESS 2601 N Whittier	
23c. DATE SIGNED 2-9-53		24a. BURIAL, CREMATION, REMOVAL (Specify)	
24b. DATE 2/14/53		24c. NAME OF CEMETERY OR CREMATORY Washington Park Cem.	
24d. LOCATION (City, town, or county) (State) St. Louis County		25. FUNERAL DIRECTOR'S SIGNATURE Penkin Toney	
DATE REC'D BY LOCAL REG. FEB 11 1953		REGISTRAR'S SIGNATURE Carl Smith MD	
25. ADDRESS 3129 Lucas		REG. mxB	

(Licensed Embalmers' 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

James A. Carter

Licensed Embalmer No. *4481*

P. O. Address *St. Louis, Mo*

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.