

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

11247

State File No. ....

FILED MAR 24 1953

2554

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</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>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>2945a Pine St.</u>		d. STREET ADDRESS (If rural, give location) <u>21</u> <u>2945a Pine St.</u> <u>0</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>ALICE</u>	b. (Middle)	c. (Last) <u>BILLIPS</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Mar. 3, 1953</u>
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5. SEX <u>Female</u> <u>3</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u> <u>2</u>	8. DATE OF BIRTH <u>1-15</u> <u>About 1850</u>	9. AGE (In years: last birthday) <u>103</u> # UNDER 1 YEAR Months <u>0</u> Days <u>0</u> # UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <u>Starksville, Miss.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>Tom Suller</u>	13b. MOTHER'S MAIDEN NAME <u>Harriette Wilson</u>	14. NAME OF HUSBAND OR WIFE
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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 <u>Willie Billips</u>	ADDRESS <u>2945a Pine St.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage - 4 days</u>		
	ANTECEDENT CAUSES *Forbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Chronic Nephritis - 6 mos.</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>			

19a. DATE OF OPERATION <u>0</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>0</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>592X</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR
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22. I hereby certify that I attended the deceased from 2/28/1953 to 3/3/1953 that I last saw the deceased alive on 3-3-1953 and that death occurred at 7 A.M., from the cause and on the date stated above.

23a. SIGNATURE <u>A.E. Hale - MD</u> (Degree or title)	23b. ADDRESS <u>822 @ N Jefferson</u>	23c. DATE SIGNED <u>3/6/53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>Mar. 9, 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Oak Dale</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u>
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DATE REC'D BY LOCAL REG. <u>MAR 7 1953</u>	REGISTRAR'S SIGNATURE <u>J. Earl Smith M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>S. J. Watson</u> ADDRESS <u>2769 Chouteau Ave.</u>
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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

*J. J. Watson*

Licensed Embalmer No. *2698*

P. O. Address *2769 Charleston*

**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.**