

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15429

State File No.

LED MAY 14 1953

BIRTH NO. 37400

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 4183

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 2219	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS MATERNITY		d. STREET ADDRESS (If rural, give location) 2/ 1418a NORTH 21 ST. STREET 0	
3. NAME OF DECEASED (Type or Print) a. (First) b. (Middle) c. (Last) ASHFORD			4. DATE OF DEATH (Month) (Day) (Year) 4-11-53
5. SEX MALE ✓	6. COLOR OR RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED. (Specify) 0	8. DATE OF BIRTH 4-11-53
9. AGE (In years last birthday)		10. UNDER 1 YEAR Months	11. UNDER 24 HRS. Hours Min. 2 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (City and State or Foreign Country) ST. LOUIS, MO. 0		12. CITIZEN OF WHAT COUNTRY? USA US	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME ANCIE BELL TINKER	
14. NAME OF HUSBAND OR WIFE NONE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) NO NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT'S SIGNATURE OR NAME ANCIE BELL ASHEORD		ADDRESS 1418a N. 21 ST. ST.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Anoxia of brain			INTERVAL BETWEEN ONSET AND DEATH
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.			
ANTECEDENT CAUSES DUE TO (b) placenta abruptio DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Caesarean Section delivery			
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? 7620			
22. I hereby certify that I attended the deceased from 4-11-1953 to 4-11-1953, that I last saw the deceased alive on 4-11-1953, and that death occurred at 1:40 P. M., from the causes and on the date stated above.			
23a. SIGNATURE Miriam M. Penroy MO		23b. ADDRESS 630 S. Kingshighway	
23c. DATE SIGNED 4-13-53			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 4-30-53	
24c. NAME OF CEMETERY OR CREMATORY Anatomical Board		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
DATE REC'D BY LOCAL REG. APR 23 1953		REGISTRAR'S SIGNATURE C. Smith MD	
25. FUNERAL DIRECTOR'S SIGNATURE R. Rowland		ADDRESS 4104 Manchester	

(Licensed Embelmer's 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.....

Licensed Embalmer No.....

P. O. Address.....

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.