

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19340

FILED JUN 1- 1953

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **4847**

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	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 1006 Atchinson	

3. NAME OF DECEASED (Type or Print) a. (First) Luvenia	b. (Middle)	c. (Last) Dowdy	4. DATE OF DEATH (Month) (Day) (Year) May 10 1953
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5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Aug. 29, 1872	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 HR. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) North Carolina	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME Steve Moore	13b. MOTHER'S MAIDEN NAME Melvanie	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)	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME George Williams	ADDRESS 4871 Fountain
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Undet.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive Cardiovascular Disease DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None			

19a. DATE OF OPERATION	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)	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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 493X
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22. I hereby certify that I attended the deceased from **5-5**, 19 **53**, to **5-10**, 19 **53**, that I last saw the deceased alive on **5-10**, 19 **53**, and that death occurred at **4:08 pm.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Edna E. Brooks	23b. ADDRESS 2601 N Whittier St.	23c. DATE SIGNED 5-12-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 5-14-53	24c. NAME OF CEMETERY OR CREMATORY Oakdale Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County Mo.
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DATE REC'D BY LOCAL REG. MAY 13 1953	REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Metropolitan Funeral System Inc.	ADDRESS 5010 Enright Ave.
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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.....

.....
working under my personal supervision.

Student
Student Embalmer

Student Embalmer No.

Signed.....

Paul V. Freeman

Licensed Embalmer No.

P. O. Address.....

*4686
1585 Ald*

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to conform to the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.