S. No. 200
v. 10.48

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FILED JUN 10 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20024

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 5342

0

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place): 8 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Homer G. Phillips 2219

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
d. STREET ADDRESS (If rural, give location): 2713 Stoddard

3. NAME OF DECEASED (Type or Print)
a. (First): Carol
b. (Middle): (Twin# 2)
c. (Last): 0 Washington

4. DATE OF DEATH (Month) 5 (Day) 17 (Year) 53

5. SEX: Fem. 3

6. COLOR OR RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 0

8. DATE OF BIRTH: 5-9-53

9. AGE (In years last birthday): If under 1 year: Months / Days 8; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and State or Foreign Country): Missouri 0

12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME (Initials only): L. D. Washington

13b. MOTHER'S MAIDEN NAME: Catherine Lloyd

14. NAME OF HUSBAND OR WIFE

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.

17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Esther M. Sherard RR2 2601 N. Whittier

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): Infectious Diarrhea

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? 7640

22. *I hereby certify that I attended the deceased from* 5-9-, 1953, *to* 5-17-, 1953 *that I last saw the deceased alive on* 5-17-, 1953, *and that death occurred at* 11:40 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE W. H. Sackler 0 (Degree or title): M. D.

23b. ADDRESS: 2601 N. Whittier

23c. DATE SIGNED: 5-20-53

24a. BURIAL, CREMATION, REMOVAL (Specify)

24b. DATE: 5-30-53

24c. NAME OF CEMETERY OR CREMATORY: Anatomical Board

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

DATE REC'D BY LOCAL REG.: MAY 28 1953

REGISTRAR'S SIGNATURE: J. Carl Smith MD

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Rowland Mortuary Service, 4104 Manchester Ave.

(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 .....
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.