

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26201**
Registrar's No. **7000**

FILED JUL 31 1953

318

1003

BIRTH NO.		REG. DIST. NO.	PRIMARY REG. DIST. NO.	Registrar's No.	
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. LENGTH OF STAY (In this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 2069		
d. FULL NAME OF HOSPITAL OR INSTITUTION 1942 BELT AVE			d. STREET ADDRESS (If rural, give location) 6 1942 BELT AVE		
3. NAME OF DECEASED a. (First) ANNIE (Type or Print)		b. (Middle) -	c. (Last) CAREY	4. DATE OF DEATH (Month) (Day) (Year) 7 12 53	
5. SEX 3 FEMALE	6. COLOR OR RACE COLORED	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW	8. DATE OF BIRTH NOV. 3, 1866	9. AGE (In years last birthday) 86 IF UNDER 1 YEAR Months 9 Days 9 IF UNDER 24 HRS. Hours 213.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NIL
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (City and State or Foreign Country) PATULSI MO.	12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME SIPIO THOMPSON		13b. MOTHER'S MAIDEN NAME LAURA		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mamie Mason 1942 BELT AVE		
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Cardiac Disease ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last... DUE TO (b) Arteriosclerosis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility			INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)		
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 443X				
22. I hereby certify that I attended the deceased from July 5, 1953 , to July 12, 1953 , that I last saw the deceased alive on July 11, 1953 , and that death occurred at 11 a. m. , from the causes and on the date stated above.					
23a. SIGNATURE (Name or title) [Signature]			23b. ADDRESS 4270 1/2 Pennyway		23c. DATE SIGNED 7-14-53
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 7-17-53	24c. NAME OF CEMETERY OR CREMATORY GREEN WOOD CEM.	24d. LOCATION (City, town, or county) (State) ST. LOUIS CTY MO		
DATE REC'D BY LOCAL REG. JUL 16 1953	REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS M. F. WALTON 2707 STODDARD		

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

Arthur L. Helliard

Licensed Embalmer No. 4221

P. O. Address 4524 Aldine

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.