

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26389**REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **6070**

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 OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		e. STREET ADDRESS (If rural, give location) 1315 Gay St	
3. NAME OF DECEASED (Type or Print) Mildred		4. DATE OF DEATH (Month) (Day) (Year) June 13 1953	
5. SEX Female		6. COLOR OR RACE Negro	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH October 21, 1907	
9. AGE (In years last birthday) 45		10. IF UNDER 1 YEAR (Month) (Day) (Hour) (Min.) 7 22	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (City and State or Foreign Country) Missouri		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Allen Smith		13b. MOTHER'S MAIDEN NAME Julia Martin	
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) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Helen Taylor - 3313 Delmar Blvd.	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Carcinoma of Liver (primary site unknown) 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.	
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? 1562		22. I hereby certify that I attended the deceased from 5-30 , 19 53 , to 6-13 , 19 53 , that I last saw the deceased alive on 6-13 , 19 53 , and that death occurred at 9:25a m., from the causes and on the date stated above.	
23. SIGNATURE (Degree or title) Chas B Williams, D.		23b. ADDRESS 2601 N Whittier	
23c. DATE SIGNED 6-15-53		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE 6/18/53		24c. NAME OF CEMETERY OR CREMATORY Greenwood	
24d. LOCATION (City, town, or county) (State) St. Louis Mo.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Atkins Bros. Und. Co. 3644 Finney Ave.	

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.....
Signature of Student Embalmer

Signed..... *John R. Cunningham*

Licensed Embalmer No..... 4476

P. O. Address..... 4223 Enright A

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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