No. 300
30.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 31 1953

State File No. 30339

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7744

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)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3119 Lawton

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Mo
b. COUNTY 2219
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis 0
d. STREET ADDRESS (If rural, give location) 21 3119 Lawton

3. NAME OF DECEASED (Type or Print) a. (First) Samuel b. (Middle) c. (Last) Poston

4. DATE OF DEATH (Month) (Day) (Year) Aug. 5, 1953

5. SEX Male 2
6. COLOR OR RACE Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 1
8. DATE OF BIRTH Mar. 4, 1865
9. AGE (In years last birthday) 88 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor
10b. KIND OF BUSINESS OR INDUSTRY Rice-Stix
11. BIRTHPLACE (City and State or Foreign Country) Farmington Mo. 0
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Samuel Poston
13b. MOTHER'S MAIDEN NAME Sarah Kennedy
14. NAME OF HUSBAND OR WIFE Georgia Poston

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME Gorgia Poston ADDRESS 3119 Lawton

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) Nephritis - (Infectious) | INTERVAL BETWEEN ONSET AND DEATH Abad 1 yr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) 1
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 ☐ 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) 600.0

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Mar 1, 1953, *to* Aug 4, 1953, *that I last saw the deceased alive on* 8/4, 1953, *and that death occurred at* 8 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE Dr. B. Key (Degree or title) 0
23b. ADDRESS 4 So. Compton
23c. DATE SIGNED 8/7/53

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal
24b. DATE Aug-8-1953
24c. NAME OF CEMETERY OR CREMATORY St. Peters Cem.
24d. LOCATION (City, town, or county) (State) St. Louis County Mo

DATE REC'D BY LOCAL REG. AUG 7 1953
REGISTRAR'S SIGNATURE J. Carl Smith MD
25. FUNERAL DIRECTOR'S SIGNATURE Sneed Funeral Home ADDRESS 3615 Easton
MJB

(Licensed Embalmer'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 Leroy H. Lannister

Licensed Embalmer No. 4523

P. O. Address 3880 Eastern

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

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