

FILED OCT 29 1953

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

37027

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 State File No. \_\_\_\_\_ Registrar's No. 9990

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 town) 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		2229 0				
d. FULL NAME OF HOSPITAL OR INSTITUTION Phillips Hospital			d. STREET ADDRESS (If rural, give location) 22 2332 R. Lasalle St.						
3. NAME OF DECEASED (Type or Print) Beatrice		a. (First)	b. (Middle)	c. (Last) Blue	4. DATE OF DEATH (Month) (Day) (Year) 10 18. 53				
5. SEX Female 3	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH Sept 15, 1950		9. AGE (In years last birthday) 3	10. MONTHS 1	11. DAYS 3	12. HOURS Hours	13. MINUTES Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and State or Foreign Country) Louisiana		12. CITIZEN OF WHAT COUNTRY? U S A			
13a. FATHER'S NAME Steve Washington.			13b. MOTHER'S MAIDEN NAME Albtra Blue		14. NAME OF HUSBAND OR WIFE None				
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. No		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Albtra Blue 2332 R. Lasalle St.					
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, asthma, etc. It means the disease, injury, or complication which caused death.			1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MEDICAL CERTIFICATION Subdural Hemorrhage Antecedent Causes Atrophy of Brain; Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) apparently suffered in fall at home, exact date and time unknown DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Accident				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT (Specify) SUICIDAL HOMICIDE Accident		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, roadside, etc.) None		21c. (CITY/TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis Mo.					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. E9040		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I saw the deceased alive on _____, 19____, and that death occurred at 12:20 P.M., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) Wm. H. Clark			23b. ADDRESS 1300 Clark			23c. DATE SIGNED 10/20/53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 10 21. 53	24c. NAME OF CEMETERY OR CREMATORY Oakdale Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County MO				
DATE REC'D BY LOCAL REG. OCT 20 1953		REGISTRAR'S SIGNATURE Earl Smith MD			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Boyd Bros Funeral Home 3706 Finney Ave				

**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 Henry C. Williams

Licensed Embalmer No. 4781

P. O. Address 1205 Walte

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

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