

STANDARD CERTIFICATE OF DEATH

State File No. **40772**
Registrar's No. **10686**

FILED NOV 24 1953

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
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) 3836a Finney	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
a. (First) Victoria		b. (Middle)	
c. (Last) Lewis		d. (Month) 11 (Day) 6 (Year) 53	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH 4/13/1893
9. AGE (In years last birthday) 60		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	
11. BIRTHPLACE (City and State or Foreign Country) unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Coffers Ruffero		13b. MOTHER'S MAIDEN NAME Silla Whitley	
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 Casey Lewis	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		19. MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH Undt	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Gangrene Left Leg	
19a. DATE 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 260x	
22. I hereby certify that I attended the deceased from 7-16 , 19 53 , to 11-6 , 19 53 , that I last saw the deceased alive on 11-6 , 19 53 , and that death occurred at 7:45 Pm. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Carl Bell Smith, M.D.		23b. ADDRESS 2601 N. Whittier	
23c. DATE SIGNED 11-9-53		24a. BURIAL, CREMATION, REMOVAL (Specify)	
24b. DATE 11/13/53		24c. NAME OF CEMETERY OR CREMATORY Washington Park	
24d. LOCATION (City, town, or county) (State) County Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Jackson Funeral Home	
25. ADDRESS 2649 Delmar		DATE REC'D BY LOCAL REG. NOV 10 1953	

WRITE PLAINLY—USING UNFAADING 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 *Leroy U. Jannister*.....

Licensed Embalmer No. *452*.....

P. O. Address *9880 C...*.....

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.