

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40858**
Registrar's No. **11283**

BIRTH NO. _____ 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) a. STATE Missouri b. COUNTY 2329	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> 0
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		e. STREET ADDRESS (If rural, give location) 222 1004 Missouri	

3. NAME OF DECEASED (Type or Print)	a. (First) Rilla	b. (Middle)	c. (Last) Melton	4. DATE OF DEATH (Month) (Day) (Year) 11 24 53
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5. SEX Female 3	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow 2	8. DATE OF BIRTH 6/4/1888	9. AGE (In years last birthday) (Months) (Days) (Hours) (Min.) 65
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Mississippi /	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Author Smith	13b. MOTHER'S MAIDEN NAME ?	14. NAME OF HUSBAND OR WIFE Lynn Melton
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Julia E. Mealy, Med. Dir. Office
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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		INTERVAL BETWEEN ONSET AND DEATH Unkt.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiovascular Accident		
	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. Hypertensive Cardiovascular Disease			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) 2329 MO
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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
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22. I hereby certify that I attended the deceased from **11-16-**, 19 **53**, to **11-24**, 19 **53** that I last saw the deceased alive on **11-24**, 19 **53**, and that death occurred at **2:10 Pm.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) E. B. Williams O.	23b. ADDRESS 2601 N. Whittier	23c. DATE SIGNED 11-25-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removed	24b. DATE Nov 30/53	24c. NAME OF CEMETERY OR CREMATORY Washington Park	24d. LOCATION (City, town, or county) (State) St. Louis MO
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DATE REC'D BY LOCAL REG. NOV 30 1953	REGISTRAR'S SIGNATURE J. C. Smith	25. FEDERAL DIRECTOR'S SIGNATURE ADDRESS F. G. Green 4214 Belmont
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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.....
F. G. Green

Licensed Embalmer No. *296*

P. O. Address *4217 Polun*

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.