

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2585

State File No.

FILED FEB 2 1954

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

Registrar's No. 0629

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 township) ST. LOUIS		c. LENGTH OF STAY (in this place) 11 months		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		e. STREET ADDRESS 4473 St. Louis Avenue		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) MARIE W. BLACKWELL		4. DATE OF DEATH (Month) (Day) (Year) JANUARY 19, 1954			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Jan. 13, 1915	9. AGE (In years last birthday) 39	10. IF UNDER 1 YEAR Months 0 Days 6
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY same		11. BIRTHPLACE (City and State or Foreign Country) Mason, Tennessee	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13a. FATHER'S NAME John Taylor		13b. MOTHER'S MAIDEN NAME Mattie L. Burchett	
14. NAME OF HUSBAND OR WIFE Ozell Blackwell		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 Ozell Blackwell, Mason, Tennessee		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.		19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ATELECTASIS OF LUNGS ANTECEDENT CAUSES DUE TO (b) HEPATIC COMA DUE TO (c) PORTAL CIRRHOSIS II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
20. INTERVAL BETWEEN ONSET AND DEATH 1 DAY 5 DAYS 5 YEARS		21a. DATE OF OPERATION		21b. MAJOR FINDINGS OF OPERATION	
21c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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? 5810		22. I hereby certify that I attended the deceased from 1-17, 1954, to 1-19, 1954, that I last saw the deceased alive on 1-19, 1954, and that death occurred at 1:50 p.m., from the causes and on the date stated above.			
23a. SIGNATURE Frank B. Northing		23b. ADDRESS M.D. BARNES HOSPITAL		23c. DATE SIGNED 1-19-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 1/20/54		24c. NAME OF CEMETERY OR CREMATORY Charleston Cemetery	
24d. LOCATION (City, town, or county) (State) Stanton, Tennessee		24e. DATE REC'D BY LOCAL REG. JAN 20 1954		24f. REGISTRAR'S SIGNATURE Charles J. Gates	
24g. FUNERAL DIRECTOR'S SIGNATURE Charles J. Gates		24h. ADDRESS 4107 Finney Ave.			

(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.....
Signature of Student Embalmer

Signed *Arthur L. Hellman*.....

Licensed Embalmer No. *42*.....

P. O. Address *4107 J*.....

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.