

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6854

State File No.

BIRTH NO. FILED MAR 8 1954 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1730

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 OR township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Infirmary		e. STREET ADDRESS (If rural, give location) 23 216a Marion		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)		a. (First) Sallie		b. (Middle)		c. (Last) Steed		4. DATE OF DEATH (Month) (Day) (Year) Feb. 22, 1954	
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5. SEX F		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH Sept. 12, 1886		9. AGE (In years last birthday) 67		10. UNDER 1 YEAR Months 5		11. UNDER 1 HR. Hours		12. UNDER 1 MIN. Min.	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Private Family		11. BIRTHPLACE (City and State or Foreign Country) States, Georgia		12. CITIZEN OF WHAT COUNTRY?	
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13a. FATHER'S NAME Joe Lay		13b. MOTHER'S MAIDEN NAME Harreit		14. NAME OF HUSBAND OR WIFE William Steed	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Walter Steed 3614 Cottage	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage						3 Days	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

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) 331X	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		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 Feb 19, 1954, to Feb 22, 1954, that I last saw the deceased alive on Feb 21, 1954, and that death occurred at 1:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Dr. Charles William M.D.		23b. ADDRESS 301 Indian Lorya Jay		23c. DATE SIGNED 2/23/54	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Feb. 26, 1954		24c. NAME OF CEMETERY OR CREMATORY Washington Park		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri	
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DATE REC'D BY LOCAL REG. FEB 23 1954		REGISTRAR'S SIGNATURE Charles Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS EP Koval 1221 N. Grand	
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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 *Ruyton Swan*.....

Licensed Embalmer No. 458

P. O. Address 1221 N. 12

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.