

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **10300**
Registrar's No. **2704**

FILED APR 2 1954 REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY 2117	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (In this place) 20 yrs.	c. CITY OR TOWN St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		e. STREET ADDRESS (If rural, give location) 4327 Garfield	

3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) Nash c. (Last) Nash			4. DATE OF DEATH (Month) (Day) (Year) 3 19 54		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Unknown 1887	9. AGE (In years last birthday) abt 67	10. CITIZEN OF WHAT COUNTRY? U.S.A.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) odd jobs		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Tigrett, Tennessee	

13a. FATHER'S NAME Austin Hicks		13b. MOTHER'S MAIDEN NAME Annie Nash		14. NAME OF HUSBAND OR WIFE Alberta Nash	
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.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS William Hicks, 4453 St. Ferdinand	

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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Undt.	
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease			
	ANTECEDENT CAUSES DUE TO (b) Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) Congestive Failure			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS 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) 420.0	
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?	

22. I hereby certify that I attended the deceased from **3-16**, 19**54**, to **3-19**, 19**54**, that I last saw the deceased alive on **3-19**, 19**54**, and that death occurred at **7:20 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) E. B. Williams, M.D.		23b. ADDRESS 2601 N. Whittier		23c. DATE SIGNED 3-19-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 3/25/54		24c. NAME OF CEMETERY OR CREMATORY Washington Park Cem.	
DATE REC'D BY LOCAL REG. MAR 24 1954		REGISTRAR'S SIGNATURE Charles J. Gates		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Charles J. Gates 4107 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.....
Signature of Student Embalmer

Signed *Arthur L. Heilbard*

Licensed Embalmer No. *42*

P. O. Address *4107 Ju*

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.