

FILED APR 21 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13193**
3161

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

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 township) St. Louis		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN St Louis, Mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
e. STREET ADDRESS 25 1418 (R) Biddle		2259	

3. NAME OF DECEASED (Type or Print) a. (First) Callie	b. (Middle)	c. (Last) Bland	4. DATE OF DEATH (Month) (Day) (Year) April 1, 1954
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5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Not Known	9. AGE (in years) (Months) (Days) (Hours) (Min.) 47 3/4
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Tenn.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Not Known	13b. MOTHER'S MAIDEN NAME Julia Harden	14. NAME OF HUSBAND OR WIFE Not Known
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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) No	16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME Ben Harden	ADDRESS Chicago Ill
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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 Undt.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Meningo Vascular Les		
	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.			

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) 026 X
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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 **Jan. 28, 1954**, to **Apr. 1, 1954**, that I last saw the deceased alive on **Apr. 1, 1954** and that death occurred **at 2:25 p. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) C. B. Williams M. D.	23b. ADDRESS 2601 N. Whittier	23c. DATE SIGNED 4/5/54
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24a. BURIAL OR CREMATION, REMOVAL (Specify) Removal	24b. DATE 4-9-54	24c. NAME OF CEMETERY OR CREMATORY Oakdale Cemetery	24d. LOCATION (City, town, or county) (State) St Louis, Mo
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DATE REC'D BY LOCAL REG. APR 7 1954	REGISTRAR'S SIGNATURE J. C. Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE A.L. Beal Und.Co.	ADDRESS 4303 Delmar
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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 *Orville R. Hughes*.....

Licensed Embalmer No. *48*.....

P. O. Address *3123 R*.....

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.