

FILED APR 21 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13316

State File No.

BIRTH NO.

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 2971

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE MO.		b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St Louis mo		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 714 S. 18th St		e. STREET ADDRESS (If rural, give location) 714 S. 18th St		228	
3. NAME OF DECEASED (Type or Print) a. (First) Laura b. (Middle) Corneal c. (Last)		4. DATE OF DEATH 3 30-54			
5. SEX Female	6. COLOR OR RACE negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Widowed	8. DATE OF BIRTH 1864	9. AGE (In years last birthday) 90	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Greenville, Ky.	12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Henry Bell		13b. MOTHER'S MAIDEN NAME Mahalieg Green		14. NAME OF HUSBAND OR WIFE	
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 Ola Freeman 714 S. 18th	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocarditis -		INTERVAL BETWEEN ONSET AND DEATH 3	
		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. Arterio Sclerosis		3	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input 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) 422.1	
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	
22. I hereby certify that I attended the deceased from March 10, 1954, to March 29, 1954, that I last saw the deceased alive on March 29, 1954, and that death occurred at 2:30 A.M., from the causes and on the date stated above.					
23a. SIGNATURE H. G. Moore M.D.		(Degree or title) 977-5018		23c. DATE SIGNED 3-31-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE April 2, 1954		24c. NAME OF CEMETERY OR CREMATORY Centralia Ill.	
24d. LOCATION (City, town, or county) (State) Centralia Ill.		DATE REC'D BY LOCAL REG. APR 2 1954		REGISTRAR'S SIGNATURE J. C. Smith M.D. English Und. Co. 1123 N. Taylor	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS			

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

(Licensed Embalmer's Statement on Reverse Side)

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 *Wallace R. Williams*

Licensed Embalmer No. *493*
4554 Lexington
P. O. Address *S. L. Lane*

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.