

FILED JUN 24 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....  
4674

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 <b>Missouri</b> b. COUNTY <b>2259</b>			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>St. Louis</b> <b>0</b> )		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <b>St. Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Homer G. Phillips Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>1727 Lucas</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Roxie</b>		b. (Middle)		c. (Last) <b>Brooks</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>5 21 54</b>		
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5. SEX <b>Female 3</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow 2</b>		8. DATE OF BIRTH <b>4/4 /1897</b>		9. AGE (In years last birthday) <b>57</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (City and State or Foreign Country) <b>Tennessee</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
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13a. FATHER'S NAME <b>Joe Gale</b>			13b. MOTHER'S MAIDEN NAME <b>Ella Turner</b>			14. NAME OF HUSBAND OR WIFE <b>Unknown</b>		
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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)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME <b>Ella Turner 3729 Windsor Pl</b>				ADDRESS	
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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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Hypertensive Cardiovascular Disease</b> <b>Incarcerated Ventral Hernia</b> ANTECEDENT CAUSES DUE TO (b) _____ DUE TO (c) _____ Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Carcinoma of Cervix</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Undt.</b>	
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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)	
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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? <b>443XH</b>	
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22. I hereby certify that I attended the deceased from **5-16**, 19**54**, to **5-21**, 19**54**, that I last saw the deceased alive on **5-21**, 19**54**, and that death occurred at **3:00 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE <b>Earl Belle Smith</b> (Degree or title) <b>M.D.</b>		23b. ADDRESS <b>2601 N. Whittier</b>		23c. DATE SIGNED <b>5/24/54</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>May 26/54</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis Mo</b>	
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DATE REC'D BY LOCAL REG. <b>MAY 26 1954</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith MD</b>		FEDERAL DIRECTOR'S SIGNATURE <b>J. A. Hean</b>		ADDRESS <b>4214 Delmar</b>	
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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 *F. A. Green*

Licensed Embalmer No. *296*

P. O. Address *4214 Delmar*

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.