

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JUL 2 - 1954

State File No. **20296**  
**5698**

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

|   |  |   |                                  |
|---|--|---|----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Missouri</b><br>b. COUNTY |                                  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b> |  | c. LENGTH OF STAY (in this place)   | c. CITY OR TOWN <b>St. Louis</b> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION: <b>1015 A. Elliot</b>                                |  | e. STREET ADDRESS (If rural, give location)<br><b>1015 A. Elliot</b>  |                                  |

|                                     |                          |             |                         |                  |                  |                 |                  |
|-------------------------------------|--------------------------|-------------|-------------------------|------------------|------------------|-----------------|------------------|
| 3. NAME OF DECEASED (Type or Print) | a. (First) <b>Lillie</b> | b. (Middle) | c. (Last) <b>Carter</b> | 4. DATE OF DEATH | (Month) <b>6</b> | (Day) <b>22</b> | (Year) <b>54</b> |
|-------------------------------------|--------------------------|-------------|-------------------------|------------------|------------------|-----------------|------------------|

|                        |                                 |  |                                  |                                 |                                     |                         |                          |                         |
|------------------------|---------------------------------|--|----------------------------------|---------------------------------|-------------------------------------|-------------------------|--------------------------|-------------------------|
| 5. SEX <b>Female 3</b> | 6. COLOR OR RACE <b>Colored</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Widowed 2</b> | 8. DATE OF BIRTH <b>6-7-1897</b> | 9. AGE (in years last birthday) | IF UNDER 1 YEAR<br>Months <b>57</b> | IF UNDER 1 YEAR<br>Days | IF UNDER 1 YEAR<br>Hours | IF UNDER 1 YEAR<br>Min. |
|------------------------|---------------------------------|--|----------------------------------|---------------------------------|-------------------------------------|-------------------------|--------------------------|-------------------------|

|   |  |  |  |
|---|--|--|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housework</b> | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b> | 11. BIRTHPLACE (City and State or Foreign Country)<br><b>Mississippi</b> | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |
|---|--|--|--|

|  |  |  |
|--|--|--|
| 13a. FATHER'S NAME<br><b>Sammy Gilliam</b> | 13b. MOTHER'S MAIDEN NAME<br><b>Evie White</b> | 14. NAME OF HUSBAND OR WIFE<br><b>Deceased</b> |
|--|--|--|

|   |  |   |                                  |
|---|--|---|----------------------------------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b> | 16. SOCIAL SECURITY NO.<br><b>None</b> | 17. INFORMANT'S SIGNATURE OR NAME<br><b>Albert Carter</b> | ADDRESS<br><b>1013 A. Elliot</b> |
|---|--|---|----------------------------------|

|   |   |  |  |
|---|---|--|--|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br><b>two weeks</b> |
|   | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Hemorrhage</b> |  |  |
|   | ANTECEDENT CAUSES<br>DUE TO (b) <b>Nephritis</b><br>DUE TO (c)                    |  |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br><b>XX</b>  |   |  |  |

|                                     |   |   |
|-------------------------------------|---|---|
| 19a. DATE OF OPERATION<br><b>XX</b> | 19b. MAJOR FINDINGS OF OPERATION<br><b>XX</b> | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
|-------------------------------------|---|---|

|  |   |   |
|--|---|---|
| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) <b>XX</b> | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>X</b> | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)<br><b>X X X</b> |
|--|---|---|

|   |  |   |
|---|--|---|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)<br><b>X</b> | 21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | 21f. HOW DID INJURY OCCUR?<br><b>XX</b> |
|---|--|---|

22. I hereby certify that I attended the deceased from **June 15, 1954**, to **June 22, 1954**, that I last saw the deceased **live on 6/22/54, 19**, and that death occurred at **3 P.** m., from the causes and on the date stated above.

|                                   |                               |  |                                    |
|-----------------------------------|-------------------------------|--|------------------------------------|
| 22a. SIGNATURE<br><i>L. Amory</i> | (Degree or title) <b>M.D.</b> | 23b. ADDRESS<br><b>2605 Franklin Ave. St. Louis, Mo.</b> | 23c. DATE SIGNED<br><b>6/23/54</b> |
|-----------------------------------|-------------------------------|--|------------------------------------|

|   |                             |   |  |
|---|-----------------------------|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b> | 24b. DATE<br><b>6-25-54</b> | 24c. NAME OF CEMETERY OR CREMATORY<br><b>Jimmy Armstrong Cemetery</b> | 24d. LOCATION (City, town, or county) (State)<br><b>Amory, Mississippi</b> |
|---|-----------------------------|---|--|

|  |  |   |                                     |
|--|--|---|-------------------------------------|
| DATE REC'D BY LOCAL REG.<br><b>JUN 25 1954</b> | REGISTRAR'S SIGNATURE<br><i>J. Earl Smith M.D.</i> | 25. FUNERAL DIRECTOR'S SIGNATURE<br><i>Ellis Funeral Home</i> | ADDRESS<br><b>2820 Stoddard St.</b> |
|--|--|---|-------------------------------------|

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

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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... *Fulton E. Culkin*

Licensed Embalmer No. *198*

P. O. Address... *St. Louis*

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.