

FILED JUN 24 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **20585**

REG. DIST. NO. **318**

PRIMARY REG. DIST. NO. **1003**

Registrar's No. **4488**

|   |  |  |   |  |  |  |  |
|---|--|--|---|--|--|--|--|
| BIRTH NO. _____   |  | REG. DIST. NO. <b>318</b>  |   | PRIMARY REG. DIST. NO. <b>1003</b>   |  | Registrar's No. <b>4488</b>  |  |
| 1. PLACE OF DEATH<br>a. COUNTY _____  |  |  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>a. STATE <b>St. Louis Missouri</b><br>b. COUNTY _____ |  |  |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br><b>St. Louis</b>                              |  | c. LENGTH OF STAY (in this place) <b>1</b>   |   | c. CITY OR TOWN <b>St. Louis</b>   |  | d. Is residence within limits of a city or incorporated town?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>5279 Page</b>  |  |  |   | e. STREET ADDRESS (If rural, give location)<br><b>5279 Page</b>  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or Print)<br>a. (First) <b>Alice</b><br>b. (Middle) <b>May</b><br>c. (Last) <b>Hanna</b> |  |  | 4. DATE OF DEATH <b>5-18-54</b><br>(Month) (Day) (Year) |  |  |  |  |
| 5. SEX <b>Female</b>  |  | 6. COLOR OR RACE <b>Colored</b>  |   | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>  |  | 8. DATE OF BIRTH <b>Oct 16 1889</b>  |  |
| 9. AGE (In years) <b>64</b><br>if under 21: last birthday Months Days   |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b> |   | 10b. KIND OF BUSINESS OR INDUSTRY _____  |  | 11. BIRTHPLACE (City and State or Foreign Country) <b>Illinois</b>   |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>US</b>  |  | 13a. FATHER'S NAME <b>Joseph Bean</b>  |   | 13b. MOTHER'S MAIDEN NAME <b>Sarah Valley</b>  |  | 14. NAME OF HUSBAND OR WIFE <b>John</b>  |  |
| 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>Lavada White</b> ADDRESS <b>5279 Page</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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____<br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>Cerebral Apoplexy</b><br>DUE TO (c) _____ |  |  |  | INTERVAL BETWEEN ONSET AND DEATH _____ |  |
| II. OTHER SIGNIFICANT CONDITIONS<br>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? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 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) <b>334X</b> (STATE) _____ |  |  |  |
| 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 3, 1954, to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at 3:15 p.m., from the causes and on the date stated above.

23a. SIGNATURE **Patricia Taylor Caladonia** (Degree or title) \_\_\_\_\_ 23b. ADDRESS **1300 Clark** 23c. DATE SIGNED **5.19.54.**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 24b. DATE **5-19-1954** 24c. NAME OF CEMETERY OR CREMATORY **Caladonia** 24d. LOCATION (City, town, or county) (State) **Sparta Ill**

DATE REC'D BY LOCAL REG. **MAY 19 1954** REGISTRAR'S SIGNATURE **J. Carl Smith** 25. FUNERAL DIRECTOR'S SIGNATURE **Lester Walker** ADDRESS **Sparta Illinois**

(Licensed Embalmer's Statement on Reverse Side)

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.....  
*J. Allen Davis*

Licensed Embalmer No. ....  
*46*

P. O. Address .....  
*H. L.*

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.