

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

7220

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) OR TOWN Saint Louis		c. LENGTH OF STAY (In this place)	c. CITY OR TOWN Saint Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION: People Hospital		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
		• STREET ADDRESS (If rural, give location) 2219 0 21 3207 Lawton	

3. NAME OF DECEASED (Type or Print) a. (First) Blanche b. (Middle) c. (Last) Abernathy			4. DATE OF DEATH (Month) (Day) (Year) 7 31 54		
5. SEX Female	6. COLOR (OR RACE) Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 10-8-1893	9. AGE (In years last birthday) 60	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
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) Desoto, Missouri	
				12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME Henry Perry	13b. MOTHER'S MAIDEN NAME Mary Edward	14. NAME OF HUSBAND OR WIFE George Abernathy
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME George Abernathy	ADDRESS 3207 Lawton
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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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Heart Disease		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Post. ulcers		
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 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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? July 31 443X
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22. I hereby certify that I attended the deceased from **July 28, 1954** to **Aug 1, 1954**, that I last saw the deceased alive on **July 31, 1954** and that death occurred at **11A m.**, from the causes and on the date stated above.

23a. SIGNATURE L. J. Horell	(Degree or title) 23b. ADDRESS 2902 Paledale	23c. DATE SIGNED 8-3-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Aug. 5, 1954	24c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery St. Louis County	24d. LOCATION (City, town, or county) (State)
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DATE REC'D BY LOCAL REG. AUG 4 1954	REGISTRAR'S SIGNATURE Paul Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE Metropolitan Funeral System, Inc.	ADDRESS 5010 Enright
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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 *Paul V. Freeman*.....

Licensed Embalmer No. *4681*

P. O. Address *4129 Hammett*.....

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.