

FILED AUG 16 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29270

State File No.

No. 300

10-48

318

1003

Registrar's No. 7298

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <u>St. Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Homer G. Phillips Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>1150 Euclid Avenue 2129</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mary</u>		b. (Middle)		c. (Last) <u>Tentman</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>August 2, 1954</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>1865</u>	
9. AGE (In years last birthday) <u>89</u>		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		IF UNDER 1 MIN. Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY <u>NIL</u>			11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo.</u>	
13a. FATHER'S NAME <u>Unknown</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>			14. NAME OF HUSBAND OR WIFE <u>Unknown</u>	
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 AND ADDRESS <u>Mary Johnson Holloway, 1150 N. Euclid</u>	
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypertensive Encephalopathy, Hypertensive Heart Disease</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) _____ DUE TO (c) _____ II OTHER SIGNIFICANT CONDITIONS <u>Marked Malnutrition & Dehydration, Hypostatic Pneumonia</u> Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>Undt</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" 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)			
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 <u>443x</u>			
22. I hereby certify that I attended the deceased from <u>July 20, 1954</u> , to <u>August 2, 1954</u> , that I last saw the deceased alive on <u>August 2, 1954</u> , and that death occurred at <u>3:45 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>E. J. Williams, M.D.</u>				23b. ADDRESS <u>2601 N. Whittier</u>		23c. DATE SIGNED <u>8/4/54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>Aug 7/54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Washington Park</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo</u>	
DATE REC'D BY LOCAL REG. <u>AUG 6 1954</u>		REGISTRAR'S SIGNATURE <u>J. C. Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <u>F. C. Green 4214 Palm or</u>			

(Licensed Embalmer's Statement on Reverse Side)

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. *286*.....

P. O. Address *4214 Solon*.....

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.