

FILED SEP 21 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **31977**  
Registrar's No. **8449**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <b>12</b>		e. STREET ADDRESS (If rural, give location) <b>25 1021 O'Fallon 22090</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Homer G. Phillips Hospital</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Mary</b> b. (Middle) _____ c. (Last) <b>Little</b>		4. DATE OF DEATH (Month) <b>9</b> (Day) <b>7</b> (Year) <b>54</b>	
5. SEX <b>Female</b>	6. COLOR (OR RACE) <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOW</b>	8. DATE OF BIRTH <b>7-1-1975</b>
9. AGE (In years last birthday) <b>79</b>		# UNDER 1 YEAR Months _____ Days _____	# UNDER 24 Hrs. Hours _____ Min. _____
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>Arkansas</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13a. FATHER'S NAME <b>? Morris</b>		13b. MOTHER'S MAIDEN NAME <b>?</b>	14. NAME OF HUSBAND OR WIFE <b>Josh Brown (deceased)</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <b>Julia E. Masley-med. Dir. office</b> ADDRESS _____
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>Generalized Arteriosclerosis</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____  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 checked="" 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 <b>4500</b>
22. I hereby certify that I attended the deceased from <b>7-19</b> , 19 <b>54</b> , to <b>9-7</b> , 19 <b>54</b> , that I last saw the deceased alive on <b>9-7</b> , 19 <b>54</b> , and that death occurred at <b>10:15A</b> m., from the causes and on the date stated above.			
23a. SIGNATURE <b>Joseph Epton</b> (Degree or title) <b>M.D.</b>		23b. ADDRESS <b>2601 N. Whittier</b>	23c. DATE SIGNED <b>9-8-54</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE <b>9-30-54</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>
		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>SEP 15 1954</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith</b>	
		25. FUNERAL DIRECTOR'S SIGNATURE <b>Rowland-Aker Mortuary Service</b> ADDRESS _____	

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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**