

FILED OCT 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35137

State File No.

318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 8983

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY None		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) St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		e. STREET ADDRESS (If rural, give location) 1803 Delmar	

3. NAME OF DECEASED (Type or Print) Mary Betts			4. DATE OF DEATH (Month) (Day) (Year) 10 3 -54		
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Sept. 1, 1922		9. AGE (In years last birthday) 32
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) Newport, Arkansas	

13a. FATHER'S NAME Otis Johnson	13b. MOTHER'S MAIDEN NAME L. A. Jenkins	14. NAME OF HUSBAND OR WIFE Willie Betts
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. Nil	17. INFORMANT'S SIGNATURE OR NAME L. A. Thomas, 512 E. 12th, Carruthersville	ADDRESS _____
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Malignant Hypertension		MO. INTERVAL BETWEEN ONSET AND DEATH Undt.
	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. Sub-Acute Glomerulonephritis		

19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input checked="" 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) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
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22. I hereby certify that I attended the deceased from 9-21, 1954, to 10-2, 1954, that I last saw the deceased alive on 10-2, 1954, and that death occurred at 4:35P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Edw. B. Williams M.D.	23b. ADDRESS 2601 N. Whittier	23c. DATE SIGNED 10-4-54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 10/4/54	24c. NAME OF CEMETERY OR CREMATORY _____	24d. LOCATION (City, town, or county) (State) Carruthersville, Mo.
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DATE REC'D BY LOCAL REG. OCT 4 1954	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE Cunningham & Moore, 2405 Marcus Avenue	ADDRESS _____
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(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..... *John K. Cunningham*

Licensed Embalmer No..... 447

P. O. Address... 2405 Marcus

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.