

FILED OCT 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35182**
Registrar's No. **9123**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE 8 Missouri b. COUNTY 4	
b. CITY (If outside corporate limits, write RURAL, and give OR TOWN St. Louis, Mo)		c. CITY (If outside corporate limits, write RURAL, and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1344 N. Leffingwell		d. STREET ADDRESS (If rural, give location) 1344 N. Leffingwell	

3. NAME OF DECEASED (Type or Print) a. (First) Ella b. (Middle) Brown c. (Last)			4. DATE OF DEATH (Month) Oct (Day) 3 (Year) 1954		
5. SEX Female		6. COLOR OR RACE Col		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	
8. DATE OF BIRTH 6-24-1893		9. AGE (In years last birthday) 61		10. IF UNDER 1 YEAR: Months _____ Days _____	
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) VA.	
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME John H James		13b. MOTHER'S MAIDEN NAME Hattie Auston	
14. NAME OF HUSBAND OR WIFE Dead		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO	

17. INFORMANT'S SIGNATURE OR NAME Annie E Tucker			ADDRESS 1344 Leffingwell		
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hyper-tension Heart Disease Secondary		DUE TO (b) _____					
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		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 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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 443x			

22. I hereby certify that I attended the deceased from **4-10, 1954** to **10-3, 1954**, that I last saw the deceased alive on **10-2, 1954**, and that death occurred at **8:10 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE J.W. Wilkerson		(Degree or title) MD		23b. ADDRESS 4141 Pine		23c. DATE SIGNED 10-5-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Oct. 7, 54		24c. NAME OF CEMETERY OR CREMATORY Winona		24d. LOCATION (City, town, or county) (State) Miss	

DATE REC'D BY LOCAL REG. OCT 8 1954		REGISTRAR'S SIGNATURE Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE Walter J. Watson		ADDRESS 2769 Chouteau	
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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
Student Embalmer

Signed S. J. Watson *S. J. Watson*

Licensed Embalmer No. 2698

P. O. Address 769 Chouteau

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 this body is not embalmed, fact should be so stated above.