

FILED OCT 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35950

State File No. _____
Registrar's No. 94211

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. _____		Registrar's No. 94211							
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY _____											
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 10 yrs		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>									
d. FULL NAME OF HOSPITAL OR INSTITUTION: Homer G Phillips Hospital				e. STREET ADDRESS (If rural, give location) 3867 Lincoln Ave											
3. NAME OF DECEASED (Type or Print) a. (First) Hycle (Hiccie)			b. (Middle) _____			c. (Last) Sellers			4. DATE OF DEATH (Month) (Day) (Year) Oct, 15, 1954						
5. SEX Female		6. COLOR OR RACE Col.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Sept, 1, 1892		9. AGE (In years last birthday) 62		10. IF UNDER 1 YEAR Months 1		11. IF UNDER 1 YEAR Days 14		12. IF UNDER 1 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil				10b. KIND OF BUSINESS OR INDUSTRY _____				11. BIRTHPLACE (City and State or Foreign Country) ? Miss.				12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME Unknown				13b. MOTHER'S MAIDEN NAME Alice Puttman				14. NAME OF HUSBAND OR WIFE None							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Johnnie Love 3935 A. St. Louis Ave.									
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) Congestive Failure of Heart 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.						INTERVAL BETWEEN ONSET AND DEATH							
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? _____											
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 8:30 p.m., from the causes and on the date stated above.															
23a. SIGNATURE (Degree or title) James M. Kelly Deputy Coroner				23b. ADDRESS 1300 Clark				23c. DATE SIGNED 10/18/54							
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 10/20/54		24c. NAME OF CEMETERY OR CREMATORY Washington Park Cem.		24d. LOCATION (City, town, or county) St. Louis Co. Mo.		(State) _____							
DATE REC'D BY LOCAL REG. OCT 18 1954		REGISTRAR'S SIGNATURE J. Earl Smith M.D.				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wright Funeral Home 3100 Easton Ave									

(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 *H. Claude Gordon*

Licensed Embalmer No. *348*

P. O. Address *4575 Al*

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.