

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **42947**  
Registrar's No. **10720**

FILED DEC 16 1954

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 <b>Mo.</b> b. COUNTY <b>St. Louis.</b>	
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 type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis Chronic Hospital.</b>		e. STREET ADDRESS (If rural, give location) <b>2514 a Whittier St.</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>Ada</b> b. (Middle) <b>Whitfield.</b> c. (Last) <b>Whitfield.</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>November 21, 1954</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>6/20/89</b>
9. AGE (In years last birthday) <b>65</b>	IF UNDER 1 YEAR Months <b>5</b>	IF UNDER 1 HR. Hours	IF UNDER 15 MIN. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (City and State or Foreign Country) <b>Ark.</b>		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME <b>Alec May</b>		13b. MOTHER'S MAIDEN NAME <b>Unk.</b>	
14. NAME OF HUSBAND OR WIFE <b>Nunnie Whitfield</b>		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. <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>O.W. Carter 2514a Whittier St.</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <b>MEDICAL CERTIFICATION</b> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Arteriosclerotic heart disease.</b> INTERVAL BETWEEN ONSET AND DEATH  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <b>4200</b>			
22. I hereby certify that I attended the deceased from <b>July 7, 1954</b> , to <b>November 21, 1954</b> , that I last saw the deceased alive on <b>Nov. 21, 1954</b> , and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <b>Palmer Bruce Bowditch MD</b>		23b. ADDRESS <b>5800 Arsenal St.</b>	
23c. DATE SIGNED <b>11-21-54</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>Nov. 27, 1954</b>	
24c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>		24d. LOCATION (City, town, or county) (State) <b>St Louis Mo</b>	
DATE REC'D BY LOCAL REG. <b>NOV 24 1954</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>E. B. Hoome 1221 N. Grand Blvd</b>	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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..... *Georgetown Swann*

Licensed Embalmer No. *458*

P. O. Address *122 1<sup>st</sup> St*

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.