

FILED FEB 7 - 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **2565**  
Registrar's No. **0625**

|                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                        |                                                                          |                                                                                 |                                                                                                                                 |                                  |                                                                                                                                      |  |
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| BIRTH NO.                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                        | REG. DIST. NO. <b>318</b>                                                |                                                                                 | PRIMARY REG. DIST. NO. <b>1003</b>                                                                                              |                                  | Registrar's No. <b>0625</b>                                                                                                          |  |
| 1. PLACE OF DEATH<br>a. COUNTY                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                        |                                                                          |                                                                                 | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Missouri</b><br>b. COUNTY |                                  |                                                                                                                                      |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR<br>TOWN <b>St. Louis</b>                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                        | c. LENGTH OF STAY (in this place)                                        |                                                                                 | c. CITY OR TOWN <b>St. Louis</b>                                                                                                |                                  | d. Is Residence within limits of a city or incorporated town?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION: <b>Homer G. Phillips</b>                                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                        |                                                                          |                                                                                 | e. STREET ADDRESS (If rural, give location)<br><b>2219 2724 Washington Avenue</b>                                               |                                  |                                                                                                                                      |  |
| 3. NAME OF DECEASED<br>(Type or Print)<br>a. (First) <b>Maggie</b><br>b. (Middle)<br>c. (Last) <b>Glass</b>                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                        |                                                                          | 4. DATE OF DEATH<br>(Month) (Day) (Year)<br><b>1-20-55</b>                      |                                                                                                                                 |                                  |                                                                                                                                      |  |
| 5. SEX<br><b>Female</b>                                                                                                                                                                                                                   | 6. COLOR OR RACE<br><b>Colored</b>                                                                                                                                                                                                                                                                                                                                                     | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Married</b> | 8. DATE OF BIRTH<br><b>10-28-1920</b>                                           | 9. AGE (in years last birthday)<br><b>34</b>                                                                                    | IF UNDER 1 YEAR<br>Days <b>2</b> | IF UNDER 24 HRS.<br>Hours <b>22</b> Min.                                                                                             |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Nil</b>                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                        | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b>                         |                                                                                 | 11. BIRTHPLACE (City and State or Foreign Country)<br><b>Moscow, Arkansas</b>                                                   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                                                                           |  |
| 13a. FATHER'S NAME<br><b>Owen Momphis</b>                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                        | 13b. MOTHER'S MAIDEN NAME<br><b>Caroline Barne</b>                       |                                                                                 | 14. NAME OF HUSBAND OR WIFE<br><b>Orville Glass</b>                                                                             |                                  |                                                                                                                                      |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                        | 16. SOCIAL SECURITY NO.<br><b>?</b>                                      | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br><b>Mary J. Shelton 2900 Lawton</b> |                                                                                                                                 |                                  |                                                                                                                                      |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.            | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Subdural Hemorrhage (invasive) apparently caused</b><br><b>in fall during epileptic spasm, exact time and place undetermined</b><br>DUE TO (b)<br>DUE TO (c)<br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. |                                                                          |                                                                                 |                                                                                                                                 |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>caused</b>                                                                                    |  |
| 19a. DATE OF OPERATION                                                                                                                                                                                                                    | 19b. MAJOR FINDINGS OF OPERATION<br><b>Accident</b>                                                                                                                                                                                                                                                                                                                                    |                                                                          |                                                                                 |                                                                                                                                 |                                  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                                  |  |
| 21a. ACCIDENT (Specify)<br><b>Accident</b>                                                                                                                                                                                                | 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) (Minute)<br><b>3533</b>                                                         |                                  |                                                                                                                                      |  |
| 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                                                                                                                    | 21f. HOW DID INJURY OCCUR?<br><b>3533</b>                                                                                                                                                                                                                                                                                                                                              |                                                                          |                                                                                 |                                                                                                                                 |                                  |                                                                                                                                      |  |
| 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 <b>11:20 p.m.</b> , from the causes and on the date stated above. |                                                                                                                                                                                                                                                                                                                                                                                        |                                                                          |                                                                                 |                                                                                                                                 |                                  |                                                                                                                                      |  |
| 23a. SIGNATURE<br><b>Dr. Carl Smith</b>                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                        |                                                                          | 23b. ADDRESS<br><b>1300 Clark</b>                                               |                                                                                                                                 |                                  | 23c. DATE SIGNED<br><b>1/22/55</b>                                                                                                   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>                                                                                                                                                                               | 24b. DATE<br><b>1-24-55</b>                                                                                                                                                                                                                                                                                                                                                            | 24c. NAME OF CEMETERY OR CREMATORY                                       |                                                                                 | 24d. LOCATION (City, town, or county) (State)<br><b>Little Rock, Arkansas</b>                                                   |                                  |                                                                                                                                      |  |
| DATE REC'D BY LOCAL REG.<br><b>JAN 22 1955</b>                                                                                                                                                                                            | REGISTRAR'S SIGNATURE<br><b>J. Carl Smith, M.D.</b>                                                                                                                                                                                                                                                                                                                                    |                                                                          |                                                                                 | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><b>Ellis Funeral Home, Inc. 2820 Stoddard St.</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 ~~.....~~ *Fulton E. Co.*

Licensed Embalmer No. *4119*

P. O. Address *S. D. ...*

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.