

FILED FEB 7 - 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **2638**  
Registrar's No. **0809**

|   |  |  |  |   |  |  |   |
|---|--|--|--|---|--|--|---|
| BIRTH NO. _____   |  | REG. DIST. NO. <b>318</b>  |  | PRIMARY REG. DIST. NO. <b>1003</b>  |  | Registrar's No. <b>0809</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 OR 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? Yes <input type="checkbox"/> No <input type="checkbox"/> |   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Homer G. Phillips Hospital</b>   |  |  |  | STREET ADDRESS (If rural, give location) <b>5119 4021 West Belle</b>  |  |  |   |
| 3. NAME OF DECEASED (Type or Print) <b>Savannah</b>   |  | a. (First)   |  | b. (Middle) <b>Herron</b>   |  | c. (Last)  |   |
| 4. DATE OF DEATH (Month) (Day) (Year) <b>1 25 55</b>  |  | 5. SEX <b>F 3</b>  |  | 6. COLOR OR RACE <b>C</b>   |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOW 2</b>  |   |
| 8. DATE OF BIRTH <b>11-16 1890</b>  |  | 9. AGE (In years last birthday) <b>64</b>  |  | 10. IF UNDER 1 YEAR Months <b>2</b>   |  | 11. IF UNDER 1 HRS. Hours Min. <b>9</b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY _____  |  | 11. BIRTHPLACE (City and State or Foreign Country) <b>Memphis TENN.</b>   |  | 12. CITIZEN OF WHAT COUNTRY? _____   |   |
| 13a. FATHER'S NAME <b>ROBT GILLIAM</b>  |  | 13b. MOTHER'S MAIDEN NAME <b>MATTIE P</b>  |  | 14. NAME OF HUSBAND OR WIFE <b>ADOLPHUS HERRON</b>  |  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>  |  | 16. SOCIAL SECURITY NO. _____  |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Bernice Tatum 4021 West Belle</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, asphyxia, etc. It means the disease, injury, or complication which caused death.  |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Generalized Arteriosclerosis</b><br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving DUE TO (b) _____ rise to the above cause (a) stating the underlying cause last.<br><br>DUE TO (c) _____<br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <b>Probable Cerebral Thrombosis</b> |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br>Undt. |
| 19a. DATE OF OPERATION _____  |  | 19b. MAJOR FINDINGS OF OPERATION _____   |  |   |  | 20. AUTOPSY?<br>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) <b>332x</b>   |  |  |   |
| 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 <b>1-22</b> , 19 <b>55</b> , to <b>1-25</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>1-25</b> , 19 <b>55</b> , and that death occurred at <b>10:25A</b> m., from the causes and on the date stated above. |  |  |  |   |  |  |   |
| 23a. SIGNATURE (Degree or title) <b>Edw. B. Williams M.D.</b>   |  | 23b. ADDRESS <b>2601 N. Whittier</b>   |  | 23c. DATE SIGNED <b>1-25-55</b>   |  |  |   |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>  |  | 24b. DATE <b>1-21-55</b>   |  | 24c. NAME OF CEMETERY OR CREMATORY _____  |  | 24d. LOCATION (City, town, or county) (State) <b>MEMPHIS TENN.</b>   |   |
| DATE REC'D BY LOCAL REG. <b>JAN 28 1955</b>   |  | REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b>   |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>A.F. Walton 2707 Stoddard</b>   |  |  |   |

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

(Licensed Embalmer's Statement on Reverse Side)

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. *34*

P. O. Address *4575*

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.