

FILED MAR 31 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH9787  
State File No. ....  
Registrar's No. 2553

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>2553</b>	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri.</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town) <b>St. Louis, Mo.</b>		c. LENGTH OF STAY (in this place) <b>5 Mo. 18 Days</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>4344 Cottage (Rear)</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Hattie</b>		b. (Middle) _____		c. (Last) <b>Johnson</b>		4. DATE OF DEATH (Month) <b>March</b> (Day) <b>19</b> (Year) <b>55</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>April 12 1880</b>	9. AGE (In years last birthday) <b>73</b>	10. MONTH <b>11</b>	11. DAY <b>7</b>	12. HOURS <b>11</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <b>Water Valley, Miss.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13a. FATHER'S NAME <b>Pat Gilmore</b>		13b. MOTHER'S MAIDEN NAME <b>George Ann Woods</b>		14. NAME OF HUSBAND OR WIFE <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Niner Woodard</b> ADDRESS <b>1355 S. 10th- Paducah, Ky.</b>			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Generalized Arteriosclerosis</b>  ANTECEDENT CAUSES <b>with Cerebral and Cardiac</b> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <b>W elements leading.</b>				INTERVAL BETWEEN ONSET AND DEATH _____	
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. HOW DID INJURY OCCUR? <b>4500</b>	
21e. TIME OF INJURY (Month) _____ (Day) _____ (Year) _____ (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <b>October 1, 1954</b> to <b>March 19, 1955</b> , that I last saw the deceased alive on <b>March 19, 1955</b> , and that death occurred at <b>10:15 A.M.</b> from the causes and on the date stated above.							
23a. SIGNATURE <b>John Duane Bowditch M.D.</b> (Degree or title)				23b. ADDRESS <b>5800 Arsenal St.</b>		23c. DATE SIGNED <b>3/19/55</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>Mar. 23, 1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>		24d. LOCATION (City, town, or county) <b>St. Louis Co. Mo.</b> (State) _____		
DATE REC'D BY LOCAL REG. <b>MAR 21 1955</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>J. H. RANDLE &amp; SON</b> ADDRESS <b>3133 Bell Ave.</b>			

S. P. (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..... *S. J. Skaton*

Licensed Embalmer No. *2690*

P. O. Address *2769 Ave*

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.