

FILED APR 18 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

13814

3107

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____				
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 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>5067 Cates</b>				<b>21290</b>		
3. NAME OF DECEASED (Type or Print)		a. (First) <b>Annie</b>		b. (Middle) _____		c. (Last) <b>Ridley</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>4 3 55</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>3-17-1891</b>		9. AGE (in years last birthday) <b>64</b>		
IF UNDER 1 YEAR Months <b>0</b>		IF UNDER 1 YEAR Days <b>16</b>		IF UNDER 24 HRS. Hours <b></b>		Min. <b></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 <b>None</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Louisiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13a. FATHER'S NAME <b>Unknown</b>			13b. MOTHER'S MAIDEN NAME <b>Katie Brown</b>			14. NAME OF HUSBAND OR WIFE <b>None</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Estella B. Grant</b>				ADDRESS <b>5067 Cates Avenue</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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Vascular Thrombosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Undt.</b>		
		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.								
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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>332x</b>						
22. I hereby certify that I attended the deceased from <b>3-23-</b> <b>1955</b> , to <b>4-3-</b> <b>1955</b> , that I last saw the deceased alive on <b>4-3-</b> <b>1955</b> , and that death occurred at <b>10:50a;</b> m., from the causes and on the date stated above.										
23a. SIGNATURE <b>Edw B. Williams</b>				(Degree or title) <b>M.D.</b>		23b. ADDRESS <b>2601 N. Whittier Street</b>		23c. DATE SIGNED <b>4-4-55</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>4-8-56</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Father Dickson</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>				
DATE REC'D BY LOCAL REG. <b>APR 7 1955</b>		REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>			25. FUNERAL DIRECTOR'S SIGNATURE <b>Ellis Funeral Home, Inc.</b>		ADDRESS <b>2820 Stoddard St.</b>			

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. Calkins*

Licensed Embalmer No. *419*

P. O. Address *St. Louis*

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.