No. 300
10.48

FILED MAY 26 1955

THE DIVISION OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 16479

BIRTH NO. _____ REG. DIST. NO. 818 PRIMARY REG. DIST. NO. 1003 Registrar's No. 4458

**1. PLACE OF DEATH**
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place): 63 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4483 Ashland Avenue

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☐
e. STREET ADDRESS (If rural, give location): 4483 Ashland Avenue 2109

**3. NAME OF DECEASED** (Type or Print)
a. (First): LUCINDA
b. (Middle):
c. (Last): BOSTICK

**4. DATE OF DEATH** (Month) (Day) (Year): May 18, 1955

**5. SEX**: Female
**6. COLOR OR RACE**: Negro
**7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify): Married
**8. DATE OF BIRTH**: Aug. 19, 1872
**9. AGE** (In years last birthday): 82 — If under 1 year: Months 8, Days 29; If under 24 hrs.: Hours, Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife
**10b. KIND OF BUSINESS OR INDUSTRY**: None
**11. BIRTHPLACE** (City and State or Foreign Country): Murphysboro, Illinois
**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13a. FATHER'S NAME**: Steve Bostick
**13b. MOTHER'S MAIDEN NAME**: Cheynie Woods
**14. NAME OF HUSBAND OR WIFE**: Dahl Bostick

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No
(If yes, give war or dates of service): --
**16. SOCIAL SECURITY NO.**: none
**17. INFORMANT'S SIGNATURE OR NAME**: Dahl Bostick, 4483 Ashland Ave.

**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, asthenia, etc. It means the disease, injury, or complication which caused death.*

**MEDICAL CERTIFICATION**

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Pneumonia — Bronchio
DUE TO (c) Senile Debility
Hypertension
Old age

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 ☐ NO ☑

**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) m.
**21e. INJURY OCCURRED** WHILE AT WORK ☐ NOT WHILE AT WORK ☐
**21f. HOW DID INJURY OCCUR?**

331X

22. *I hereby certify that I attended the deceased from* 5-2-55, 19__, *to* 5-17-, 1955, *that I last saw the deceased alive on* 5-19-, 1955, *and that death occurred at* 1:20 a m., *from the causes and on the date stated above.*

**23a. SIGNATURE** (Degree or title): D. H. Winston
**23b. ADDRESS**: 2743 Franklin
**23c. DATE SIGNED**: 5-20-55

**24a. BURIAL, CREMATION, REMOVAL** (Specify): Removal
**24b. DATE**: 5/24/1955
**24c. NAME OF CEMETERY OR CREMATORY**: Washington Park Cemetery
**24d. LOCATION** (City, town, or county) (State): St. Louis County, Mo.

DATE REC'D BY LOCAL REG.: MAY 20 1955
REGISTRAR'S SIGNATURE: J. Carl Smith MD
**25. FUNERAL DIRECTOR'S SIGNATURE** ADDRESS: Charles J. Gates, 4107 Finney Ave.
(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 emba

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Arthur L. Hilliard

Licensed Embalmer No. 422

P. O. Address 4107 Finney

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fa
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.