

FILED AUG 2-1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **23742**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5594**

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</b>	c. LENGTH OF STAY (In this place) <b>16 days</b>	c. CITY OR TOWN <b>St. Louis</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. LOUIS CHILDREN'S HOSPITAL</b>		STREET ADDRESS (If rural, give location) <b>2229 22 2215 Spruce St.</b>	
3. NAME OF DECEASED a. (First) <b>MARCIA</b> (Type or Print)		b. (Middle) <b>LYNN</b>	
c. (Last) <b>FRANCIS</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>6 25 55</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>NEVER - MARRIED</b>	8. DATE OF BIRTH <b>5-30-54</b>
9. AGE (In years last birthday) <b>1</b>		IF UNDER 1 YEAR Months <b>25</b>	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			

13a. FATHER'S NAME <b>Cordell Francis</b>	13b. MOTHER'S MAIDEN NAME <b>Offett</b>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <b>St. Louis Children's Hospital - 500 S. Kingshighway</b>	ADDRESS
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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) <b>Aspiration Pneumonia</b>		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) <b>Jacksonian Convulsions</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		DUE TO (c)		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>103</b>
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22. I hereby certify that I attended the deceased from **6-9**, 19**55**, to **6-25**, 19**55**, that I last saw the deceased alive on **6-25**, 19**55**, and that death occurred at **9:30A** m., from the causes and on the date stated above.

23a. SIGNATURE <b>Dr. L. Smith MD</b> (Degree or title)	23b. ADDRESS <b>500 S. Kingshighway St. Louis 10, Mo.</b>	23c. DATE SIGNED <b>6-25-55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>7-2-1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>	24d. LOCATION (City, town, or county) (State) <b>ST. LOUIS, MO.</b>
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DATE REC'D BY LOCAL REG. <b>JUN 28 1955</b>	REGISTRAR'S SIGNATURE <b>Charles Smith MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Dunn Funeral Home</b>	ADDRESS <b>215 So. J.</b>
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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. Hester*

Licensed Embalmer No. *249*

P. O. Address *2749*

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.