

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JAN 6 1956

State File No. **42484**  
Registrar's No. **10859**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>	
1. PLACE OF DEATH a. COUNTY <b>St. Louis-Missouri</b>			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 township) OR TOWN		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 checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>D. O. A. Homer G. Phillip</b>			e. STREET ADDRESS (If rural, give location) <b>10 4291 E. St. Louis Ave</b>		
3. NAME OF DECEASED (Type or Print) <b>Eugenia</b>			a. (First)	b. (Middle)	c. (Last) <b>Osborne</b>
4. DATE OF DEATH (Month) (Day) (Year) <b>Dec 6, 1955</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Col</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>6/15/1901</b>	9. AGE (in years last birthday) <b>54</b>	10. IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY <b>Day Work</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Okolona Mississippi</b>		12. CITIZEN OF WHAT COUNTRY? <b>yes</b>	
13a. FATHER'S NAME <b>Jhon Brooks</b>		13b. MOTHER'S MAIDEN NAME <b>Martha Brooks</b>		14. NAME OF HUSBAND OR WIFE <b>Dead</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>No</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs Essie Mae Johnson</b> ADDRESS <b>3120 Newstead</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>Coronary Thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12-6-55</b>
			ANTECEDENT CAUSES 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) m.		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>12/6, 1955</b> , to <b>12/6, 1955</b> , that I last saw the deceased alive on <b>12-6, 1955</b> , and that death occurred at <b>77 m.</b> , from the causes and on the date stated above.					
23. SIGNATURE <b>James T. Aldrich M.D.</b> (Degree or title)			23b. ADDRESS <b>7621 1/2 Franklin Ave</b>		23c. DATE SIGNED <b>12-10-55</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>12/12/55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis County</b>		
DATE REC'D BY LOCAL REG. <b>DEC 12 1955</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Herman J. Smith</b> ADDRESS <b>4247/w Labadie Ave</b>	

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 *W. Claude G. Lamm*

Licensed Embalmer No. *348*

P. O. Address *457 Eld.*

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.