

FILED JAN 17 1956

STANDARD CERTIFICATE OF DEATH

42648

State File No. _____

318

1003

11409

BIRTH NO. _____

REG. DIST. NO. _____

PRIMARY REG. DIST. NO. _____

Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis)		c. LENGTH OF STAY (in this place) 4 yrs.		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		STREET ADDRESS (If rural, give location) 21 2232 A. Carr Street 2219			
3. NAME OF DECEASED (Type or Print) a. (First) Mariah b. (Middle) c. (Last) Splong		4. DATE OF DEATH (Month) 12 (Day) 24 (Year) 55			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Not known	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Miss	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME not known		13b. MOTHER'S MAIDEN NAME not known	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT'S SIGNATURE OR NAME Rev A.P. Florence		ADDRESS 2232 Carr St			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Thrombosis. 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.			INTERVAL BETWEEN ONSET AND DEATH Undt.
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 332x		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?	
22. I hereby certify that I attended the deceased from 11-18- , 19 55 , to 12-24- , 19 55 , that I last saw the deceased alive on 12-24- , 19 55 , and that death occurred at 5:25a m., from the causes and on the date stated above.					
23a. SIGNATURE E. B. Williams		(Degree or title) M.D.		23b. ADDRESS 2601 N. Whittier Street	
23c. DATE SIGNED 12-28-55		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 12-29-55	
24c. NAME OF CEMETERY OR CREMATORY Oakdale Cem.		24d. LOCATION (City, town, or county) (State) St. Louis Mo.			
DATE REC'D BY LOCAL REG. DEC 28 1955		REGISTRAR'S SIGNATURE Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE Beal Und. Co.	
				ADDRESS 4303 Delmar	

(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 *Daniel Hughes*

Licensed Embalmer No. 48

P. O. Address

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