

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28239

FILED SEP 6 1956

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **7325**

| | | | |
|---|--|---|--|
| 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 township) OR TOWN St. Louis | | c. CITY OR TOWN St. Louis | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Homer Phillips Hospital | | e. STREET ADDRESS (If rural, give location) 21 2330 Cole | |

| | | | | | |
|---|--|-------------|---|----------------|--|
| 3. NAME OF DECEASED (Type or Print) OSCAR | | | 4. DATE OF DEATH (Month) (Day) (Year) 8 - 3 - 56 | | |
| a. (First) | | b. (Middle) | | c. (Last) | |
| | | | | CONNORS | |

| | | | | | | | | | | | | | | | |
|--|--|-------------------------------|--|---|--|---------------------------------|--|--|--|---------------------------------|--|---|--|--|--|
| 5. SEX Male | | 6. COLOR OR RACE Negro | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | | 8. DATE OF BIRTH Unknown | | 9. AGE (In years last birthday) abt 62 | | 10. IF UNDER 1 YEAR Months Days | | 11. IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil | | | | 10b. KIND OF BUSINESS OR INDUSTRY None | | | | 11. BIRTHPLACE (City and State or Foreign Country) Macon, Miss. | | | | 12. CITIZEN OF WHAT COUNTRY? USA | | | |

| | | | | | | | | |
|-----------------------------------|--|--|--|--|--|---|--|--|
| 13a. FATHER'S NAME Unknown | | | 13b. MOTHER'S MAIDEN NAME Unknown | | | 14. NAME OF HUSBAND OR WIFE Lizzie Connors | | |
|-----------------------------------|--|--|--|--|--|---|--|--|

| | | | | | | | |
|---|--|---|--|---|--|--------------------------|--|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 427-42-7983 | | 17. INFORMANT'S SIGNATURE OR NAME Lizzie Connors | | ADDRESS 2330 Cole | |
|---|--|---|--|---|--|--------------------------|--|

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | | MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH Undet. | |
| <p>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</p> | | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Arteriosclerosis | | | | | | | |
| | | 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. Chronic Pyelonephritis Arteriosclerotic Heart Disease | | | | | | | |

| | | | | | | | | | |
|------------------------|--|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION Disease | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) (Min.) | | 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 **7-17**, 19 **56**, to **8-3**, 19 **56**, that I last saw the deceased alive on **8-3**, 19 **56** and that death occurred at **9:45 a m.**, from the causes and on the date stated above.

| | | | | | | | | | | | |
|-----------------------------------|--|--|-------------------------------|--|--|--|--|--|--------------------------------|--|--|
| 23a. SIGNATURE Hugh Waters | | | (Degree or title) M.D. | | | 23b. ADDRESS 2601 N. Whittier St. | | | 23c. DATE SIGNED 8-8-56 | | |
|-----------------------------------|--|--|-------------------------------|--|--|--|--|--|--------------------------------|--|--|

| | | | | | | | |
|--|--|--------------------------|--|---|--|---|--|
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24b. DATE 8/10/56 | | 24c. NAME OF CEMETERY OR CREMATORY Washington Park | | 24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo | |
|--|--|--------------------------|--|---|--|---|--|

| | | | | | | | |
|--|--|---|--|---|--|---------------------------------|--|
| DATE REC'D BY LOCAL REG. AUG 8 1956 | | REGISTRAR'S SIGNATURE J. Carl Smith M.D. | | 25. FUNERAL DIRECTOR'S SIGNATURE G. Wade Granberry | | ADDRESS 4202 Finney Ave. | |
|--|--|---|--|---|--|---------------------------------|--|

P. (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 *Melvin E. Green*.....

Licensed Embalmer No. *442*.....

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.