

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28959

STATE FILE NUMBER

FILED SEP 6 1956

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

7172

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>Madison</u> c. CITY <u>Collinsville</u> OR TOWN <u>Collinsville</u> <u>8/29</u> d. STREET ADDRESS <u>418 Summit Ave.</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Mo.</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u> Length of stay in 1b		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>NMN</u> Last <u>PEGUES</u> <u>Pegues</u>			4. DATE OF DEATH Month <u>August</u> Day <u>1</u> Year <u>1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 15 1901</u>	9. AGE (In years last birthday) <u>55</u>	IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maid</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fairmount Race Track Cafe</u>		11. BIRTHPLACE (City and state or country) <u>Mississippi</u>	
13. FATHER'S NAME <u>Henry Crimes</u>			14. MOTHER'S MAIDEN NAME <u>Vinnie Moody</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>338-18-8333</u>		17. INFORMANT <u>Nettie Fields</u> <u>Collinsville Ill</u> <u>418 Summit</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c) <u>33 1/2 H</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of cervix (primary site) 1 1/2 yrs.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>7:55</u> Month, Day, Year a. m. <u>A.M.</u> p. m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE

21. I attended the deceased from July 11, 1956 to Aug. 1, 1956 and last saw her/him alive on Aug. 1, 1956
Death occurred at 7:55 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>FR Malley</u> (Degree or title)	22b. ADDRESS <u>BARNES HOSPITAL</u>	22c. DATE SIGNED <u>8/1/56</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>8/4/56</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. John</u>	23d. LOCATION (City, town, or county) (State) <u>Collinsville Ill.</u>
24. FUNERAL DIRECTOR <u>F. M. C. Green</u> ADDRESS <u>4060 Washington Blvd.</u>	25. DATE RECD. BY LOCAL REG. <u>AUG 3 1956</u>	26. REGISTRAR'S SIGNATURE <u>J. Carl Smith, M.D.</u> <u>C.M.</u>	

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MAR 1959

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. *44*

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.