

FILED JAN 15 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43246

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar **11997**

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, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips			Length of stay in 1b		d. STREET ADDRESS (If outside, give location) 119 S. Channing		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Bessie			First Middle Last Jamison		4. DATE OF DEATH Month Day Year 12 27 56								
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-17-1907		9. AGE (In years last birthday) 49		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic			10b. KIND OF BUSINESS OR INDUSTRY Private Home		11. BIRTHPLACE (City and state or country) Houston, Texas			12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Joseph Starkey				14. MOTHER'S MAIDEN NAME unknown									
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. none		17. INFORMANT Willie Jamison			Address 119 S. Channing					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage										INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to above cause (a): DUE TO (b) Hypertensive Cardiovascular Disease										Undet.			
DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										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.) Cardiac Insufficiency										
20c. TIME OF INJURY Hour Month, Day, Year a. m. 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 12-24-56 to 12-27-56 and last saw her her alive on 12-27-56 Death occurred at 7:18 a. m. on the date stated above; and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) Dough Waters, M.D.						22b. ADDRESS 2601 N. Whittier St.			22c. DATE SIGNED 12-28-56				
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 12-31-56		23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery			23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.						
24. FUNERAL DIRECTOR Atkins Bros.				ADDRESS 3644 Finney		25. DATE RECD. BY LOCAL REG. DEC 29 1956		26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D.					

(Licensed Embalmer's Statement on Reverse Side)

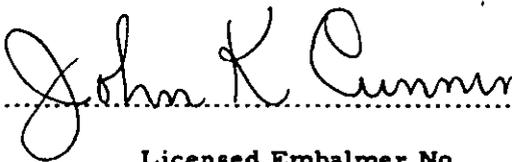
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE. Coroner cannot certify to a death due to natural causes. diseases in Part I must be causally related.

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was
by me, or by, Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....


Licensed Embalmer No.....

P. O. Address...2405 Marc

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