

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

FILED FEB 6 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2821
STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **557**

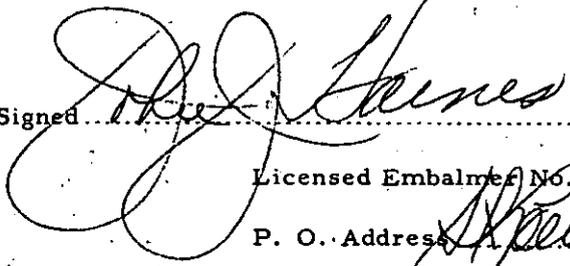
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Missouri Baptist			Length of stay in lb 7 Years	d. STREET ADDRESS 2835 Hampton Ave.		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Annie			First	Middle	Last Holmes	4. DATE OF DEATH Month Jan. Day 17, Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 25, 1899		9. AGE (In years last birthday) 57	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) Housewife			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Summitt, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wylie Craft				14. MOTHER'S MAIDEN NAME Beatrice Caruth			
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 Address John Holmes, 2835 Hampton Ave.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular hemorrhage							INTERVAL BETWEEN ONSET AND DEATH 5 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) ESSENTIAL HYPERTENSION				
			DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 331X							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 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 Dec 12 '56 to Jan 17 '57 and last saw ^(her) (him) alive on Jan 17 '57 Death occurred at 1:20 P m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Warren M. Pomeroy MD (Degree or title)				22b. ADDRESS 457 N. Kings Highway		22c. DATE SIGNED 1-17-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 1-17-57	23c. NAME OF CEMETERY OR CREMATORY Local		23d. LOCATION (City, town, or county) Memphis, Tenn.		(State)	
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, 4700 Washington Blvd.			25. DATE RECD. BY LOCAL REG. JAN 18 '57		26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D. S.P.		

(Licensed Embalmer's Statement on Reverse Side)

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 
Licensed Embalmer No.
P. O. Address

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.