

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

10905

FILED MAR 27 1957

STATE FILE NUMBER

318

1003

2135

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY								
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Saint Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>						
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>			Length of stay in lb <b>246</b>		STREET ADDRESS <b>4822 Northland</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Alice</b>				First <b>Alice</b>		Middle		Last <b>Priest</b>		4. DATE OF DEATH Month <b>2</b> Day <b>28</b> Year <b>57</b>		
5. SEX <b>Female 3</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 4, 1881</b>		9. AGE (In years last birthday) <b>75</b>		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Yazoo, City, Mississippi</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Bill Anderson</b>						14. MOTHER'S MAIDEN NAME <b>Unknown</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Georgia Jones 1918 St. Louis</b>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Insufficiency</b>										INTERVAL BETWEEN ONSET AND DEATH <b>undet.</b>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										DUE TO (b) <b>Hypertensive Cardiovascular Disease</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Malnutrition - Generalized Arteriosclerosis - Dehydration</b>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2		
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 Month, Day, Year a. m. p. m.												
20d. INJURY OCCURRED. WHILE AT <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 <b>2-27-57 5:00 am</b> to <b>2-28-57 10:50 pm</b> last saw her <del>her</del> <b>alive on 2-28-57</b> Death occurred at <b>10:50 P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.												
22a. SIGNATURE <b>Hugh Waters</b> , M.D.						22b. ADDRESS <b>2601 Whittier Street</b>			22c. DATE SIGNED <b>3-1-57</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>Mar. 6, 1957</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park Cemetery St. Louis County, Mo.</b>				23d. LOCATION (City, town, or county) (State)				
24. FUNERAL DIRECTOR <b>Metropolitan Funeral System, Inc.</b> ADDRESS <b>5010 Enright</b>				25. DATE RECD. BY LOCAL REG. <b>MAR 4 '57</b>		26. REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>						

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Health, & Welfare Public Service  
S. 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.

**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..... *John K. Cunningham*  
Licensed Embalmer No. *447*

P. O. Address *2405 Ma*

**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.**