

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15051

FILED APR 26 1957

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2642**

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

| | | | | | | | |
|--|----------------------------------|---|--|---|--|--|--|
| 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 St. Louis City #1 | | | Length of stay in lb | STREET ADDRESS 2207 Market St. (If outside, give location) | | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First IDA Middle MAE Last MILLS | | | | 4. DATE OF DEATH Month APR Day 13 Year 1957 | | | |
| 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 3-29-1884 | 9. AGE (In years last birthday) 73 | 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 none | | 11. BIRTHPLACE (City and state or country) Fulton, Missouri | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Clay Hockaday | | | | 14. MOTHER'S MAIDEN NAME Lucinda Jordan | | | |
| 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 Mr. Aaron Mills - 2207 Market St. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis of right middle cerebral Artery Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) Hypertension DUE TO (c) 332x | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 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"/> 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 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 3-9-57 to 4-13-57 and last saw her alive on 4-13-57 Death occurred at 6:40 PM m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) John W. Strigich M.D. | | | | 22b. ADDRESS 2317 So. 13th St. | | 22c. DATE SIGNED 4-14-57 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 4-19-57 | 23c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery | | 23d. LOCATION (City, town, or county) St. Louis County, Mo. | | (State) | |
| 24. FUNERAL DIRECTOR Atkins Bros. | | ADDRESS 3644 Finney Ave. | | 25. DATE RECD. BY LOCAL REG. APR 16 57 | | 26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D. | |

(Licensed Embalmer's Statement on Reverse Side)

S.P.

John S. First No. 2

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. 4476

P. O. Address 2405 Marcus

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.