

Health, Welfare Public Service

300 1-56

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED JUL 31 1957

THE DIVISION OF HEALTH OF MISSOURI STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 26634 6902

Registration District No. 318 Primary Registration District No. 1003 Registrar's 6902

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 <i>St. Louis, Mo.</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>St. Louis</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Homer G. Phillips Hosp.</i>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <i>2617 1/2 Rear Franklin</i>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <i>Josephine Thomas</i>			4. DATE OF DEATH Month Day Year <i>7 21 1957</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 30, 1887</i>		9. AGE (In years last birthday) <i>70</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Nil</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (City and state or country) <i>St. Louis, Missouri</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Joe Lambert</i>			14. MOTHER'S MAIDEN NAME <i>Annie ?</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No None</i>		16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT Address <i>Marguerite Boyd 2905 a. Easton Ave.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive Heart Disease</i> DUE TO (b) <i>Senility</i> DUE TO (c) <i>443x</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH
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 <i>7-18-1957</i> to <i>7-20-1957</i> and last saw her/him alive on <i>7-20-57</i> Death occurred at <i>10:45 P m</i> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <i>John A. Williams M.D.</i>			22b. ADDRESS <i>2617 1/2 Franklin Ave.</i>		22c. DATE SIGNED <i>7-22-57</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>7/27/57</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Greenwood Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>St. Louis County, Missouri</i>	
24. FUNERAL DIRECTOR <i>Und Co</i> ADDRESS <i>C.W. Roberts 1416 N. Taylor Ave</i>			25. DATE RECD. BY LOCAL REG. <i>Jul 24 57</i>	26. REGISTRAR'S SIGNATURE <i>Carl Smith M.D.</i> <i>MBS</i>	

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 *James A. Carter*

Licensed Embalmer No. *46*

P. O. Address *J. L.*

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.