

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29147

STATE FILE NUMBER

7846

FILED SEP 4 1957

Registration District No. **318** Primary Registration District No. **1003** 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>		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>		d. STREET ADDRESS <b>3307 Lawton</b>	
3. NAME OF DECEASED (Type or print) <b>Susie</b>		4. DATE OF DEATH <b>8 21 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/></b> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 19, 1898</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		9b. AGE (In years last birthday) <b>59</b>	
10a. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (City and state or country) <b>Miss.</b>	
13. FATHER'S NAME <b>unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Juanita Jackson</b> Address	
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>Cerebral Thrombosis</b>  DUE TO (b) <b>Arteriosclerosis</b>  DUE TO (c) <b>33 2x</b>  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  <b>undet.</b>
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. TIME OF INJURY <b>Hour Month, Day, Year</b> <b>a. m. p. m.</b>		20c. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
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		20g. COUNTY STATE	
21. I attended the deceased from <b>8-18-57</b> to <b>8-21-57</b> and last saw her <del>alive</del> <b>alive</b> on <b>8-21-57</b> Death occurred at <b>2:10 A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Maurice Roseau, M.D.</b>		22b. ADDRESS <b>2601 Whittier Street</b>	
22c. DATE SIGNED <b>8-21-57</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>8-26-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis county, Mo</b>
24. FUNERAL DIRECTOR <b>English</b>	25. DATE RECD. BY LOCAL REG. <b>AUG 21 57</b>	26. REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b> <b>S.P.</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *Wallace P. Williams*

Licensed Embalmer No. *49*

P. O. Address *4554 Sec*

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.