

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 21 1957

42757

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10964**

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		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		Length of stay in lb 27	
3. NAME OF DECEASED (Type or print) Jessie Warren		4. DATE OF DEATH Month 11 Day 14 Year 57	
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 August 19, 1898
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY House Wife	11. BIRTHPLACE (City and state or country) Olkoma Mississippi
13. FATHER'S NAME William Sutton		14. MOTHER'S MAIDEN NAME Anna Green	
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.	
17. INFORMANT James Warren		Address 4332 St Louis 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) ANTERIOR SPINAL ARTERY THROMBOSIS			INTERVAL BETWEEN ONSET AND DEATH undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) _____ DUE TO (c) _____
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 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 - 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 10-25-57 to 11-14-57 and last saw her alive on 11-14-57 Death occurred at 10:03 A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Paul M. Larn (Degree or title)		22b. ADDRESS 2601 Whittier Street	
22c. DATE SIGNED 11-15-57			
23a. BURIAL, CREMATION, REMOVAL (Specify) Rem oval		23b. DATE 11/19/57	
23c. NAME OF CEMETERY OR CREMATORY Greenwood		23d. LOCATION (City, town, or county) (State) County	
24. FUNERAL DIRECTOR Herman J. Smith ADDRESS 4247/w Labadie		25. DATE RECD. BY LOCAL REG. NOV 16 57	
26. REGISTRAR'S SIGNATURE J. Paul Smith, M.D.			

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 *H. Claude Gordon*

Licensed Embalmer No. *340*

P. O. Address *4575 Al*

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.