

Health, & Welfare Public Service

FILED JAN 13 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

46399  
STATE FILE NUMBER  
Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12541

S. 300  
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>St. Clair</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>East St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Mary's Inf.</u>		Length of stay in lb <u>2</u> days	d. STREET ADDRESS (If outside, give location) <u>1922 Trendley Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>GEORGIA</u> Middle <u>MAE</u> Last <u>TRIPLETT</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>25</u> Year <u>1957</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 6, 1912</u>	9. AGE (In years last birthday) <u>45</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Tulsa, Oklahoma</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>GUS BAKER</u>	13b. MOTHER'S MAIDEN NAME <u>FANNIE WHITE</u>	14. NAME OF HUSBAND OR WIFE <u>PERCY TRIPLETT</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>320-20-9117</u>	17. INFORMANT Address <u>1922 Trendley East St. Louis, Ill.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
DUE TO (b) <u>Phlebotrombosis of the legs</u>		
DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Carcinoma of the cervix grade TV 463XH</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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.)
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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
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21. I attended the deceased from <u>May 1955</u> to <u>Dec 25, 1957</u> and last saw her alive on <u>Dec 25, 1957</u> Death occurred at <u>7:05 pm</u> on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>Chas R. May Jr MD</u> (Degree or title)	22b. ADDRESS <u>1469 Kansas</u>	22c. DATE SIGNED <u>12/27/57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>12/27/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Garden of Memory Stookey Township, Ill.</u>	23d. LOCATION (City, town, or county) (State)
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24. FUNERAL DIRECTOR <u>Monroe Office</u>	ADDRESS <u>2114 Mo. Ave. East St. Louis, Ill.</u>	DATE RECD. BY LOCAL REG. <u>DEC 28 57</u>	26. REGISTRAR'S SIGNATURE <u>J. Earl Smith - MD</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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.

1911-12-10

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 Cronoff* .....

Licensed Embalmer No. *4356* .....  
P. O. Address *St Louis Mo* .....

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.