

FILED MAY 14 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-016535

STATE FILE NUMBER

3925

Registration District No. 318 Primary Registration District No. 1003

Registrar's No.

300
-57

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 checked="" type="checkbox"/> No <input type="checkbox"/>	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 1b 27	d. STREET ADDRESS (If outside, give location) 2217 821 No. Compton
3. NAME OF DECEASED (Type or print) First Middle Last Odelia Tate		4. DATE OF DEATH Month Day Year 4 6 58	
5. SEX Female 3	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 2	8. DATE OF BIRTH Aug. 18, 1896
9. AGE (In years last birthday) 61		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	11. BIRTHPLACE (City and state or country) Brownville, Tenn.
10a. USUAL OCCUPATION		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME William Smith		13b. MOTHER'S MAIDEN NAME Mollie ?	14. NAME OF HUSBAND OR WIFE
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 Address Mildred Owens 821 N. Compton 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) CEREBRAL THROMBOSIS DUE TO (b) CEREBRAL ARTERIOCLEROSIS Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 332x			INTERVAL BETWEEN ONSET AND DEATH undet.
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 <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 4-5-58 7:50A to 4-6-58 4:40P and last saw her alive on 4-6-58 Death occurred at 4:40 P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Paul M. Larson, M.D.		22b. ADDRESS 2601 Whittier Street	22c. DATE SIGNED 4-7-58
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Apr. 12, 1958	23c. NAME OF CEMETERY OR CREMATORY Washington Park	23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
24. FUNERAL DIRECTOR J. H. RANDLE & SON		ADDRESS 3133 Bell Ave.	25. DATE RECD. BY LOCAL REG. APR 8 '58
			26. REGISTRAR'S SIGNATURE Carl Smith, M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Ethel Harris*

Licensed Embalmer No. *4458*
P. O. Address *4181 Wash*

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.