

(THE DIVISION OF HEALTH OF MISSOURI)  
**STANDARD CERTIFICATE OF DEATH**

58-19859  
STATE FILE NUMBER

FILED JUN 11 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5590

300  
1-57

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 <b>St. Louis</b> TOWN		c. CITY OR TOWN <b>St. Louis</b>	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>		d. STREET ADDRESS (If outside, give location) <b>1000 N. 19th</b>	
Length of stay in 1b		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Annie King</b>			4. DATE OF DEATH Month Day Year <b>5 26 58</b>
5. SEX <b>Female 3</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-14-1897</b>
9. AGE (In years last birthday) <b>60</b>		10. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (City and state or country) <b>Mississippi</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (City and state or country) <b>Mississippi</b>	
13a. FATHER'S NAME <b>Tom Walker</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	
14. NAME OF HUSBAND OR WIFE <b>Deceased</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>Howard King</b> Address <b>1395 Granville</b>	
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>			INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>CEREBRAL ARTERIOSCLEROSIS</b>			<b>undet.</b>
DUE TO (c) <b>332x</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>CORONARY ARTERY DISEASE.</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <b>5-18-58</b> to <b>5-26-58</b> and last saw her alive on <b>5-26-58</b> Death occurred at <b>12:35</b> <b>A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Paul W. Larson</b> (Degree or title) <b>M.D.</b>		22b. ADDRESS <b>2601 Whittier Street</b>	
22c. DATE SIGNED <b>5-27-58</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>5-31-58</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Greenwood</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>	
24. FUNERAL DIRECTOR <b>Ellis Funeral Home</b>		ADDRESS <b>2820 Stoddard St.</b>	
25. DATE RECD. BY LOCAL REG. <b>MAY 28 '58</b>		26. REGISTRAR'S SIGNATURE <b>J. Carl Smith, M.D.</b> <b>S.P.</b>	

(Licensed Embalmer's Statement on Reverse Side)

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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 Gulton C. Culkin

Licensed Embalmer No. 4198

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.