

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-030096

STATE FILE NUMBER

8096

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

FILED AUG 28 1958

1. PLACE OF DEATH a. COUNTY <u>2701A Cass</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
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>St. Louis 6</u>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>01 2701 A CASS</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>2219 2701 CASS</u>
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>AMMIE</u> Middle <u>KELLY</u> Last <u>ADAMS</u>			4. DATE OF DEATH Month <u>8</u> Day <u>18</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>3 NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>3-15-1901</u>	9. AGE (In years last birthday) <u>57</u>	IF UNDER 1 YEAR Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY <u>MAID</u>	11. BIRTHPLACE (City and state or country) <u>MEMPHIS, TENNESSEE</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
---------------------------------------------------------------------------------------------	--------------------------------------------------	-------------------------------------------------------------------------	-----------------------------------------------

13a. FATHER'S NAME <u>UNKNOWN</u>	13b. MOTHER'S MAIDEN NAME <u>Liddie Woods</u>	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) <u>NO</u>	16. SOCIAL SECURITY NO. <u>499-28-2793</u>	17. INFORMANT <u>ARTHUR Reddie</u>	Address <u>2701 A CASS</u>
---------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------	---------------------------------------	-------------------------------

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>cerebral apoplexy</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
DUE TO (b) <u>Hypertension</u>		
DUE TO (c) <u>334x</u>		
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 type="checkbox"/> NO <input checked="" 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 <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 MAR. 1958 to AUG. 18-1958 and last saw her alive on AUG. 18-1958
Death occurred at 12:45 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Walter H. Young</u> (Name or title) MD	22b. ADDRESS <u>2337 Market</u>	22c. DATE SIGNED <u>8/19/58</u>
----------------------------------------------------------	---------------------------------	---------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>8-23-58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>OAK DALE CEMETERY</u>	23d. LOCATION (City, town, or county) <u>LEMAU, MISSOURI</u>
------------------------------------------------------------	-----------------------------	----------------------------------------------------------------	-----------------------------------------------------------------

24. FUNERAL DIRECTOR <u>Hill & Radford</u>	ADDRESS <u>1913 N Grand</u>	25. DATE RECEIVED BY LOCAL REG. <u>AUG 20 1958</u>	26. REGISTRAR'S SIGNATURE <u>J. Carl Smith</u>
---------------------------------------------------	--------------------------------	-------------------------------------------------------	---------------------------------------------------

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 *Leroy W. Dennis*
Licensed Embalmer No. *4523*
P. O. Address *4251 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.