

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-038007

STATE FILE NUMBER

FILED OCT 30 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

9892

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 TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <b>2326 Coleman</b>
			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Lurendia</b> Middle <b>Martin</b> Last			4. DATE OF DEATH Month <b>10</b> Day <b>13</b> Year <b>58</b>			
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>3 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>5-29-1881</b>	9. AGE (In years last birthday) <b>77</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (City and state or country) <b>Eleps Alabama</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
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13a. FATHER'S NAME <b>David Hynes</b>	13b. MOTHER'S MAIDEN NAME <b>Emery Clark</b>	14. NAME OF HUSBAND OR WIFE <b>Robert Martin</b>
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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) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Euna Norflet</b>	Address <b>2326 Rear Cole St.</b>
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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) <b>CEREBRAL THROMBOSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Undet.</b>
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Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) **CEREBRAL ARTERIOSCLEROSIS**

DUE TO (c) **332X**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)  
**MALNUTRITION & DEPEND RATION**

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 _____ Month, Day, Year _____ a.m. _____ p.m. _____
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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 <b>10-4-58</b> to <b>10-13-58</b> and last saw <del>her</del> <b>her</b> alive on <b>10-13-58</b> Death occurred at <b>6:30</b> p. _____ m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE <b>Paul H. Larson</b> (Degree or title)	22b. ADDRESS <b>N.D. 2601 N. Whittier St.</b>	22c. DATE SIGNED <b>10-14-58</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10-20-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Co. Mo.</b> <b>5500 Brown Road</b>
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24. FUNERAL DIRECTOR <b>G. J. Golden</b>	ADDRESS <b>3404 Delmar</b>	25. DATE RECD. BY LOCAL REG. <b>OCT 16 58</b>	26. REGISTRAR'S SIGNATURE <b>J. Carl Smith Mo</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

St. Louis, Mo.  
Lower G. Phillips

Female  
Luncheon  
Martin

STATEMENT BY LICENSED EMBALMER

x 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 \_\_\_\_\_  
XX

Signed *Leroy U. Annister*  
Licensed Embalmer No. *4523*

P. O. Address *4251 Washington*

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.