Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-007417
STATE FILE NUMBER

FILED MAR 10 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 1718

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Homer G. Phillips — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 4432 Kennerly — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Sophia — Middle: — Last: Marshall
4. DATE OF DEATH: Month 2 — Day 14 — Year 59
5. SEX: Female .3
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb 18 1879
9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (City and state or country): Madison Parish La.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME: Anthony Clendening
13b. MOTHER'S MAIDEN NAME: Sophie Clendening
14. NAME OF HUSBAND OR WIFE: Deceased
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs. Flossie Wofford — Address: 4432 Kennerly

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 450.0
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Atony Bladder & urinary retention, Bronchopneumonia
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 12-29-58, to 2-14-59 and last saw her alive on 2-14-59
Death occurred at 2:15 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: F. O. Richards (Degree or title) , M.D.
22b. ADDRESS: 2601 Whittier Street
22c. DATE SIGNED: 2-16-59

23a. BURIAL, CREMATION, REMOVAL (Specify):
23b. DATE: 2/19/59
23c. NAME OF CEMETERY OR CREMATORY: Washington Park
23d. LOCATION (City, town, or county): St. Louis County (State): MO.

24. FUNERAL DIRECTOR: Herman J. Smith — ADDRESS: 4247 W. Labadie
25. DATE RECD. BY LOCAL REG.: FEB 18 '59
26. REGISTRAR'S SIGNATURE: Hearl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 W. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 4575 Alde

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.