

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007687

STATE FILE NUMBER
2 2157

FILED MAR 10 1959

Registration District No. Primary Registration District No. Registrar No.

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, Mo.		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 2417 No. Garrison	
3. NAME OF DECEASED (Type or print) First Lula Middle Last Suggs		4. DATE OF DEATH Month 2 Day 27 Year 59	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-5-1973
9. AGE (In years last birthday) 85		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) ALABAMA
12. CITIZEN OF WHAT COUNTRY? USA.		13a. FATHER'S NAME Not known	
13b. MOTHER'S MAIDEN NAME Not known		14. NAME OF HUSBAND OR WIFE Dr. Suggs	
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 Ed. Suggs, 2417 N. Garrison		Address	
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 AND 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)			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 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 2-12-59 to 2-27-59 and last saw her ^{her} his alive on 2-27-59 Death occurred at 7:05 P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Paul H. Larson		22b. ADDRESS 2601 Whittier Street	
22c. DATE SIGNED 2-2-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) 3-4-59		23b. DATE	
23c. NAME OF CEMETERY OR CREMATORY Greenwood		23d. LOCATION (City, town, or county) (State) St. Louis County Mo	
24. FUNERAL DIRECTOR W.D. Richardson 2625 Glasgow		25. DATE REG. BY LOCAL REG. MAR 2 59	
26. REGISTRAR'S SIGNATURE Moand 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 *D.P. Richardson*

Licensed Embalmer No. *9928*
P. O. Address *City*

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.