

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014986

FILED APR 24 1959

Registration District No. _____ Primary Registration District No. _____ State File Number 3448
Registered No. 3448

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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		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 2420 Cass (If outside, give location)	
3. NAME OF DECEASED (Type or print) Mamie Ganaway		4. DATE OF DEATH Month 4 Day 4 Year 59	
5. SEX Female ³	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 JAN 31, 1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NIL		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Nashville, Tenn.
13a. FATHER'S NAME WILLIAM TIDWELL		13b. MOTHER'S MAIDEN NAME KATE ²	12. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	17. INFORMANT HAZEL GIBSON Address 2420 Cass APT 601
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 HEMORRHAGE			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) 331X			
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"/> 2			
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 _____ a.m. _____ p.m. Month, Day, Year _____			
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> 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	
21. I attended the deceased from 4-1-59 to 4-4-59 and last saw her alive on 4-4-59 Death occurred at 5:00 P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Paul M. Larson (Degree or title) M.D.		22b. ADDRESS 2601 Whittier Street	
22c. DATE SIGNED 4-6-59			
23a. BURIAL, CREMATION, REMOVAL (Specify) 4-10-59		23b. DATE	
23c. NAME OF CEMETERY OR CREMATORY WASHINGTON PARK Cem.		23d. LOCATION (City, town, or county) ST. LOUIS CTY (State) MO	
24. FUNERAL DIRECTOR A.F. WALTON ADDRESS 2707 Stoddard St.		25. DATE RECD. BY LOCAL REG. APR 8 '59	
26. REGISTRAR'S SIGNATURE Earl 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 *H. Claude Gordon*

Licensed Embalmer No. *3489*
P. O. Address *4575 Alh*

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.