

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-023450  
STATE FILE NUMBER

FILED JUL 7 1959

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar No. 5779

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1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Louis</b>		Inside Limits Y <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer Phillips Hospital</b>			Length of stay in 1b		d. STREET ADDRESS <b>2735 Delmar Blvd.</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Hazel Withers Tasker</b>				First Middle Last		4. DATE OF DEATH <b>June 16, 1959</b>		Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Col.</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>Aug, 10, 1918</b>		9. AGE (In years just birthday) <b>40</b>	IF UNDER 1 YEAR Months <b>10</b> Days <b>6</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic Work</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Bliver, Tenn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>Usa.</b>		
13a. FATHER'S NAME <b>Ben Withers</b>			13b. MOTHER'S MAIDEN NAME <b>Ola Jones</b>			14. NAME OF HUSBAND OR WIFE <b>None</b>			
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>Ben withers 3850 Easton Ave.</b>				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) <b>Massive intra cranial hemorrhage (extensive sub-dural and sub-arachnoid hemorrhage).</b> DUE TO (b) <b>904.0</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>21</b>								INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. PLACE OF INJURY OCCURRED (Enter only in PART I or PART II) <b>slipped in fall in bath room of home on June 14, 1959.</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour a.m. <b>6</b> Month, Day, Year <b>14 1959</b> p.m.		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.) <b>214 Royal</b>		20f. CITY, TOWN, OR LOCATION <b>St. Louis Mo</b>		COUNTY STATE	
21. I attended the deceased from _____ and last saw her alive on _____ Death occurred at <b>1000 P.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <b>Paul Simon Deputy Coroner</b>				(Degree or title) <b>3</b>		22b. ADDRESS <b>1300 Clark</b>		22c. DATE SIGNED <b>6/18/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>6/22/59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park Cemetery</b>			23d. LOCATION (City, town, or county) <b>St. Louis Co. Mo.</b>		(State)	
24. FUNERAL DIRECTOR <b>Wright Funeral Home</b>				ADDRESS <b>3100 Easton Ave.</b>		25. DATE RECD. BY LOCAL REG. <b>JUN 18 '59</b>		26. REGISTRAR'S SIGNATURE <b>Lead Smith, M.D.</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

m & B

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 *Arthur L. Hillia*

Licensed Embalmer No. *4221*

P. O. Address *3100 East*

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.