

**DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-025049**

**FILED VS JUL 12 1960**

**318**

Primary Registration District No. **1003**

Registrar's No. **6704**

STATE FILE NUMBER

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>	Length of stay in 1b <b>Unk.</b>	c. CITY OR TOWN <b>St. Louis</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>		d. STREET ADDRESS <b>1229a N. Taylor</b>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Georgia</b> Middle <b>Wagner</b> Last -----	4. DATE OF DEATH Month <b>6</b> Day <b>29</b> Year <b>60</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>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>12/14/82</b>	9. AGE (last birthday) <b>77</b>	IF UNDER 1 YEAR Months <b>6</b> Days <b>15</b>	IF UNDER 24 HR Hours ----- Min. -----
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	11. BIRTHPLACE (City and state or country) <b>? Tenn.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>George Anderson</b>	13b. MOTHER'S MAIDEN NAME <b>Mattie Fitzpatrick</b>	14. NAME OF HUSBAND OR WIFE -----
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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 Address <b>Hospital Records 1601 No. Whittier</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>Probably Recurrent Cerebral Thrombosis</b>	INTERVAL BETWEEN ONSET AND DEATH <b>Undet.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) ----- DUE TO (c) -----	<b>332x</b>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Osteoarthritis and Senility</b>	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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 ----- a.m. ----- p.m. ----- Month, Day, Year -----
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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 **5-14-60** to **6-29-60** and last saw <sup>her</sup>him alive on **6-29-60**  
Death occurred at **4:20 p.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>Robert J. Dickson</i> (Degree or title)	22b. ADDRESS <b>2601 N. Whittier St.</b>	22c. DATE SIGNED <b>7-1-60</b>
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23a. BURIAL, CREMATION, RECOVERY (Specify) <b>Removal</b>	23b. DATE <b>7/5/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Father Dickson</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County Missouri</b>
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24. FUNERAL DIRECTOR <b>Jas H. Randle &amp; Son</b>	ADDRESS <b>3133 Bell Ave.</b>	25. DATE RECD. BY LOCAL REG. <b>JUL 2 1960</b>	26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>
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(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*MSB*

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_ or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_ working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed Esther R. Harris

Licensed Embalmer No. 445

P. O. Address 4181 5th

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.