SOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10865 STATE FILE NUMBER 61-042661

FILED DEC 1 1961

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Length of stay in 1b: 2 days
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Chronic Hosp. — Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo. b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 4057a Olive St. — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Alice — Middle: — Last: Mc Cants
4. DATE OF DEATH: Month 11 Day 19 Year 61
5. SEX: Female
6. COLOR OR RACE: Col.
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 11-1-1876
9. AGE (last birthday): 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HR: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: Nill
11. BIRTHPLACE (City and state or country): Miss.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: Unk.
13b. MOTHER'S MAIDEN NAME: Unk.
14. NAME OF HUSBAND OR WIFE: Dead
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: No
17. INFORMANT: Mr Alphonso Matthews — Address: 4270 Labadie Ave

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): Cerebrovascular Thrombosis
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b): Cerebral Arteriosclerosis
DUE TO (c): 332x
INTERVAL BETWEEN ONSET AND DEATH:
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

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 11-16-61, to 11-19-61 and last saw her/him alive on 11-19-61
Death occurred at 9:20 p.m. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Am Huggins, M.D.
22b. ADDRESS: 634 N. Grand
22c. DATE SIGNED: 11-20-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 11/24/61
23c. NAME OF CEMETERY OR CREMATORY: Washington Park
23d. LOCATION (City, town, or county) (State): St. Louis County Missouri

24. FUNERAL DIRECTOR: Herman J. Smith — ADDRESS: 4247/Labadie Ave
25. DATE RECD. BY LOCAL REG.: NOV 22 1961
26. REGISTRAR'S SIGNATURE: Paul Smith, M.D.

DOCUMENT

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Arthur L. Heilliard

Licensed Embalmer No. 4221

P. O. Address 3100 Easton

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp 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.