MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1737 STATE FILE NUMBER 62-008018

FILED FEB 23 1962

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Homer G. Phillips
Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY

c. CITY OR TOWN: St. Louis
Inside Limits Yes ☐ No ☐

d. STREET ADDRESS (If outside, give location): 4144a Easton
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Mary Middle: Etta Last: Farmer

4. DATE OF DEATH: Month 2 Day 8 Year 62

5. SEX: Female

6. COLOR OR RACE: Negro

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH: 10-21-[illegible]

9. AGE (last birthday): 58
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): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (City and state or country): Mississippi

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Hence Sledge

13b. MOTHER'S MAIDEN NAME: Texanna Partee

14. NAME OF HUSBAND OR WIFE: Deceased

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: ?

17. INFORMANT: Joseph Lee Farmer-5594 A Easton Ave Address

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): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: Undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Hypertension — Undet.
DUE TO (c): 33/X

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 2-2-62, to 2-8-62 and last saw her alive on 2-8-62
Death occurred at 10:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Sydney A. Frances (Degree or title) M. D.

22b. ADDRESS: 2601 N. Whittier Street

22c. DATE SIGNED: 2-8-62

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 2-13-62

23c. NAME OF CEMETERY OR CREMATORY: Washington Park Cemetery

23d. LOCATION (City, town, or county): St. Louis (County) (State): MO.

24. FUNERAL DIRECTOR: Ellis Funeral Home ADDRESS: 2820 Stoddard St.

25. DATE RECD. BY LOCAL REG.: FEB 13 1962

REGISTRAR'S SIGNATURE: Noal Smith, M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS: DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | BY AFFIDAVIT OF | DOCUMENT

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 Fulton E. Culkin

Licensed Embalmer No. 4198

P. O. Address Francis

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.