MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED APR 6 1962

-62-012792
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3428

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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2 219
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USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.	SHOULD READ	INSTEAD OF	DATE AMENDED

BY AFFIDAVIT OF DOCUMENT

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 Phillips H osp.
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): 508 N. Sarah Street
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First Leola; Middle; Last Holmes

4. DATE OF DEATH: Month 3; Day 28; Year 62

5. SEX: Female

6. COLOR OR RACE: Col.

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH: Abt

9. AGE (last birthday): 63

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): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (City and state or country): Pulaski, Miss.

12. CITIZEN OF WHAT COUNTRY: USA

13a. FATHER'S NAME: John Washington

13b. MOTHER'S MAIDEN NAME: Susie Huntington

14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Lillie V. Blanton
Address: 508 N. Sarah

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): Cardio Vascular -
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Hypertension
DUE TO (c): 443x

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 1/20/62, to 3/28/62 and last saw her/him alive on 3/28/62
Death occurred at 9:P m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: W. C. Bridges (Degree or title)

22b. ADDRESS: 4056 W. Bell Pl

22c. DATE SIGNED: MAR 31 196

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

23b. DATE: 4-2-62

23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery

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

24. FUNERAL DIRECTOR: A.L. Beal Und. Co.
ADDRESS: 4303 Delmar

25. DATE RECD. BY LOCAL REG.: MAR 31 1962

26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

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. Thelliard

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 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.