

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13555
3368

FILED APR 27 1949

State File No. _____
Registrar's No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUIS	c. LENGTH OF STAY (If this place) 1 18 45	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2830^e BERNARD.		d. STREET ADDRESS (If rural, give location) 2830^e BERNARD.	

3. NAME OF DECEASED (Type or Print) Jessie	a. (First)	b. (Middle) Armster	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) 4 10 49
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5. SEX FEMALE	6. COLOR OR RACE Col	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 5-15-1902	9. AGE (In years last birthday) 46	IF UNDER 1 YEAR Months Days	IF UNDER 1 MIN. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work denoting most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) MISSISSIPPI	12. CITIZEN OF WHAT COUNTRY? U.S.
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13a. FATHER'S NAME John White	13b. MOTHER'S MAIDEN NAME Bertha Barnett	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME William White	ADDRESS 2830^e Bernard
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Caner of Stomach		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Hx 151X		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) H. W. Wilson M.D.	23b. ADDRESS 4141 Rye	23c. DATE SIGNED 4-5-1949
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-15-49	24c. NAME OF CEMETERY OR CREMATORY Washington Park St Louis Mo	24d. LOCATION (City, town, or county) (State) St Louis Mo
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DATE REC'D BY LOCAL REG. APR 14 1949	REGISTRAR'S SIGNATURE J. B. Jasater	25. FUNERAL DIRECTOR'S SIGNATURE Bernie Love	ADDRESS 3103 Washington
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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.

Signed.....

W. C. Lande Gordon

Signed.....
Student Embalmer

Licensed Embalmer No. *3489*

P. O. Address *4575 Alder*

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 this body is not embalmed, fact should be so stated above.