

FILED MAY 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13687**
Registrar's No. **3773**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis)		c. CITY (If outside corporate limits, write RURAL and give township) Saint Louis	
c. LENGTH OF STAY (in this place) 34 yrs		d. STREET ADDRESS (If rural, give location) 4427 Page Blvd.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4427 Page Blvd.			
3. NAME OF DECEASED (Type or Print) a. (First) Willa		b. (Middle) Cross	
c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) 4/22/49	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH 11/3/1894
9. AGE (in years last birthday) 54		IF UNDER 1 YEAR Months Days 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 --	
11. BIRTHPLACE (State or foreign country) Farmington, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Harold Glover		13b. MOTHER'S MAIDEN NAME Margaret Henson	
14. NAME OF HUSBAND OR WIFE Clyde Cross			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT'S SIGNATURE OR NAME Alma Adair		ADDRESS 1628 Carr Drive	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage ANTECEDENT CAUSES DUE TO (b) Hypertension <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>	
INTERVAL BETWEEN ONSET AND DEATH Terminal		undet.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
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) 83			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 321 X			
22. I hereby certify that I attended the deceased from April 19 19 49 to April 22, 19 49 that I last saw the deceased alive on April 22 19 49 , and that death occurred at 2:45 m. , from the causes and on the date stated above.			
23a. SIGNATURE [Signature] (Degree or title) M.D.		23b. ADDRESS 11 N. Jefferson Avenue	
23c. DATE SIGNED 4/27/49			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 4/28/1949	
24c. NAME OF CEMETERY OR CREMATORY Washington Park		24d. LOCATION (City, town, or county) (State) Saint. Louis Co. Missouri	
DATE REC'D BY LOCAL REG. Apr 27 1949		25. FUNERAL DIRECTOR'S SIGNATURE Chas. J. Gates ADDRESS 4107 Finney Ave.	

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

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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 _____

John K. Cunningham

Signed _____

Student Embalmer

Licensed Embalmer No. 4476

P. O. Address 4107 7th

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.