

FILED JUN 7 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **17710**
4768
Registrar's No. _____

BIRTH NO. _____ REG. DIST. NO. **0001** PRIMARY REG. DIST. NO. **818**

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, Mo)		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 1928 a. N. Whittier St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1928 a. N. Whittier St			

3. NAME OF DECEASED (Type or Print) a. (First) Annie	b. (Middle) M	c. (Last) Smith	4. DATE OF DEATH (Month) (Day) (Year) 5 / 28 / 49
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5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH 5/14/1881	9. AGE (In years last birthday) 68	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Hours	IF UNDER 15 MIN. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) ?, Arkansas	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Zack Meeks	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Dead
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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 Alice Robinson	ADDRESS 1928 a. N. Whittier
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18. NO. 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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 5/24/49 5/28/49
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c)		
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) St. Louis Mo
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 331X
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22. I hereby certify that I attended the deceased from **May 17, 1949** to **May 28, 1949**, that I last saw the deceased alive on **May 24, 1949** and that death occurred at **3:30 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE W. H. Clark M.D.	(Degree or title)	23b. ADDRESS 2748^a Franklin	23c. DATE SIGNED 5/28/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6/2/49	24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis Mo
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE MAY 31 1949	25. FUNERAL DIRECTOR'S SIGNATURE C. W. Roberts	ADDRESS 1416 N. Taylor Ave.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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. 290

working under my personal supervision.

Student

James Carter
Student Embalmer

Signed

Fulton C. Culkin

Licensed Embalmer No. 4198

P. O. Address

St. Louis 13

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.