

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

27894

State File No. \_\_\_\_\_

FILED SEP 12 1949

318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 7582

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 1003		Registrar's No. 7582	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>MO</u>			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>St. Louis</u> )		c. LENGTH OF STAY (In this place township) <u>Abt 28 yrs</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		17	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Homer G Phillips Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>17 - 4125 W. Belle Apt. 300</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>WILLIE</u>		b. (Middle) _____		c. (Last) <u>BROADNAX</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>August 28 1949</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>3/5/1900</u>	
9. AGE (In years last birthday) <u>49</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 HR. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chipper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Scullins Steel</u>		11. BIRTHPLACE (State or foreign country) <u>Columbia, Louisiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Joe Broadnax</u>		13b. MOTHER'S MAIDEN NAME <u>Magnolia Clay</u>		14. NAME OF HUSBAND OR WIFE <u>Louvrita Broadnax</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Louvrita Broadnax, 4125 W. Belle</u>			
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypertensive Heart Disease</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Undetermined</u> DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Chronic Nephritis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Undet.</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) <u>151</u>			
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? <u>592X</u>			
22. I hereby certify that I attended the deceased from <u>8-22</u> , 19 <u>49</u> , to <u>8-28</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>8-28</u> , 19 <u>49</u> , and that death occurred at <u>9:30 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>E. Howard Williams M. D.</u>				23b. ADDRESS <u>2601 N. Whittier St.</u>		23c. DATE SIGNED <u>8-29-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>9/3/49</u>		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) <u>Alexandria, Louisiana</u>	
DATE REC'D BY LOCAL REG. <u>AUG 31 1949</u>		REGISTRAR'S SIGNATURE <u>John Foster</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Chas. J. Gates, 4107 Finney Avenue</u>			

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. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed John B Cunningham

Licensed Embalmer No. 4476

P. O. Address 4107 Finney Avenue

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.