

FILED NOV 25 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39416

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **9689**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri Mo b. COUNTY St Louis	
b. CITY (If outside corporate limits, write RURAL and give township) St Louis MO.		c. LENGTH OF STAY (in this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		c. CITY (If outside corporate limits, write RURAL and give township) St Louis	
3. NAME OF DECEASED a. (First) Mollie		d. STREET ADDRESS (If rural, give location) 4603 St Ferdinand St	
b. (Middle)		c. (Last) Weldon	
4. DATE OF DEATH Nov. 7 1949		5. SEX F. S.	
6. COLOR OR RACE Col.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	
8. DATE OF BIRTH Unknown		9. AGE (In years last birthday) 74	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Carinthia Miss.		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Sallie Sturberfield	
14. NAME OF HUSBAND OR WIFE Sherman Waldon		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Eveylan Foed ADDRESS 4603 St Ferdinand Ave.	
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) Prob. Pulmonary Embolism ANTECEDENT CAUSES Hypertensive Heart Disease with <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> Decompensation DUE TO (b) Hypertensive Heart Disease with DUE TO (c) Decompensation II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>	
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) St Louis MO	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? Hypertensive		22. I hereby certify that I attended the deceased from 10-27 , 1949, to 11-7 , 1949, that I last saw the deceased alive on 11-7 , 1949, and that death occurred at 3:55 pm. , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) Edward B Williams Jr. M. D.		23b. ADDRESS 2601 N Whittier St	
23c. DATE SIGNED 11-8-49		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 11/12/49		24c. NAME OF CEMETERY OR CREMATORY Father Dickson	
24d. LOCATION (City, town, or county) (State) St Louis MO		25. FUNERAL DIRECTOR'S SIGNATURE John H. Humphreys ADDRESS 408 S. Johnson Ave	
DATE REC'D BY LOCAL REG. NOV 10 1949		REGISTRAR'S SIGNATURE [Signature]	

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.....

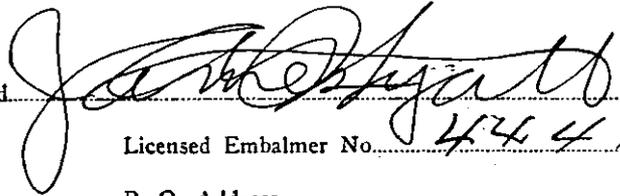
..... Student Embalmer No.

working under my personal supervision.

Student

Student Embalmer

Signed



Licensed Embalmer No. 47441

P. O. Address.....

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.