

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUL 29 1950

State File No. **25410**
Registrar's No. **6204**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003	
1. PLACE OF DEATH a. COUNTY City			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY City		
b. CITY OR TOWN SAINT LOUIS, Mo.		c. LENGTH OF STAY (in this place) 30 days	c. CITY OR TOWN St. Louis		2059
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL			d. STREET ADDRESS (If rural, give location) 627 Clara Ave.		
3. NAME OF DECEASED (Type or Print) a. (First) FRANCES		b. (Middle) L	c. (Last) WHITLOW		4. DATE OF DEATH (Month) (Day) (Year) July 18 1950
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH MARCH 18, 1898	9. AGE (In years last birthday) 52	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Astor Hat Shop	11. BIRTHPLACE (State or foreign country) Jackson, Miss.		12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME unknown		13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE Charles H. Whitlow	
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 Charles H. Whitlow ADDRESS 627 Clara 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lymphosarcoma, generalized 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. Bronchopneumonia,			INTERVAL BETWEEN ONSET AND DEATH 7 1/2 mos. 10 days
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) _____		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? 19 ft.				
22. I hereby certify that I attended the deceased from May 18, 1950 , to July 18, 1950 , that I last saw the deceased alive on July 18, 1950 , and that death occurred at 5:00 P.m. , from the causes and on the date stated above.					
23a. SIGNATURE Eugene P. Standley (Degree or title) M.D.			23b. ADDRESS Barnes Hospital, St. Louis, Mo.		23c. DATE SIGNED 7-18-50
24a. BURIAL OR CREMATION REMOVAL (Specify) Burial	24b. DATE July 20, 1950	24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cem.	24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.		
DATE REC'D BY LOCAL REG. JUL 19 1950	REGISTRAR'S SIGNATURE J. B. Laster		25. FUNERAL DIRECTOR'S SIGNATURE W. Anderson ADDRESS 6175 Delmar St. L.		

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 _____

working under my personal supervision.

Signed.....
Student Embalmer

Signed.....

Student Embalmer No.

Licensed Embalmer No. 4343

P. O. Address

St. Louis, Mo.

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.