

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42868
10410

State File No. _____
Registrar's No. _____

FILED DEC 18 1950

318

1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____

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

1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis c. LENGTH OF STAY (in this place) _____ d. FULL NAME OF HOSPITAL OR INSTITUTION: Homer G Phillips Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY _____ c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis d. STREET ADDRESS (If rural, give location) 11a South Rankin	
3. NAME OF DECEASED (Type or Print) Myrtle a. (First) _____ b. (Middle) _____ c. (Last) Spears		4. DATE OF DEATH (Month) (Day) (Year) Dec. 4 1950	
5. SEX Female 3 6. COLOR OR RACE Colored 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH May 16, 1905 9. AGE (In years last birthday) 45 IF UNDER 1 YEAR: Months 6 Days 18 IF UNDER 2 HRS. 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 None		11. BIRTHPLACE (State or foreign country) St. Louis, Missouri 12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13a. FATHER'S NAME Henry Jackson 13b. MOTHER'S MAIDEN NAME Della Coates 14. NAME OF HUSBAND OR WIFE Albert Spears			
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. None 17. INFORMANT'S SIGNATURE OR NAME C. N. T. Stanley ADDRESS 4038 St. Ferdinand	
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) Hypertensive Heart Disease with ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Congestive Failure DUE TO (c) Pulmonary Congestion	
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) _____			
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? 4250			
22. I hereby certify that I attended the deceased from 11-15 , 19 50 , to 12-4 , 19 50 , that I last saw the deceased alive on 12-4 , 19 50 , and that death occurred at 5:40a m., from the causes and on the date stated above.			
23a. SIGNATURE <i>C. N. T. Stanley</i> (Degree or title) _____ 23b. ADDRESS 2601 N Whittier St. 23c. DATE SIGNED 12-5-50			
24a. BURIAL, CREMATION, REINTERMENT (Specify) Burial 24b. DATE 12-8-50 24c. NAME OF CEMETERY OR CREMATORY Washington Park 24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.			
DATE REC'D BY LOCAL REG. DEC 6 1950 REGISTRAR'S SIGNATURE <i>J. B. Lester</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>E. B. Rance</i> ADDRESS 1221 N. Grand	

0291 4 .00

Under

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.

Student Embalmer No.....

Signed *Lawrence Brown*

Signed.....
Student Embalmer

21-1

Licensed Embalmer No. *4753*

P. O. Address *1221 N Grand*

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.