No. 300
10.48

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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25100

FILED JUL 28 1951

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 6431

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis, Missouri
c. LENGTH OF STAY (In this place): 38Hrs 15M.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): The Peoples Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Illinois
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Madison 8120
d. STREET ADDRESS (If rural, give location): 928 Jackson Street 8

3. NAME OF DECEASED (Type or Print)
a. (First): Frankie
b. (Middle): Lee
c. (Last): Palms

4. DATE OF DEATH (Month) (Day) (Year): May 27, 1951

5. SEX: Male 2
6. COLOR OR RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single 1
8. DATE OF BIRTH: May 26, 1951
9. AGE (In years last birthday): IF UNDER 1 YEAR — Months: ; Days: 1 — IF UNDER 24 HRS. — Hours: 14 ; Min.: 15

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): St. Louis, Missouri
12. CITIZEN OF WHAT COUNTRY?: U

13a. FATHER'S NAME: —
13b. MOTHER'S MAIDEN NAME: Mary Palms
14. NAME OF HUSBAND OR WIFE: None

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME: X Mary Palms
ADDRESS

MEDICAL CERTIFICATION

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.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Mega cephalus — 16 hrs

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 ☐ NO ☐

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 750 X

22. *I hereby certify that I attended the deceased from* 5/26, 19 51, *to* 5/27, 19 51, *that I last saw the deceased alive on* 5/27, 19 51, *and that death occurred at* 12 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [illegible] M.D.
23b. ADDRESS: [illegible] Ill.
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: JUL 19 1951
24c. NAME OF CEMETERY OR CREMATORY: Anatomical Bury
24d. LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG.: JUL 19 1951
REGISTRAR'S SIGNATURE: [illegible]

25. FUNERAL DIRECTOR'S SIGNATURE
ADDRESS: Rowland Mortuary Service Inc.
(Licensed Embalmer's Statement 4a (Revised)) 4000 Chester Ave. St. Louis 10, Mo.

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.....

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.