

FILED NOV 8 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35064
9324

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Illinois</u> b. COUNTY <u>St. Clair</u>			
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		c. LENGTH OF STAY (If this place) <u>3 das.</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Lovesey</u>		812-0	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Mary's Infirmary</u>				d. STREET ADDRESS (If rural, give location) <u>510 Madison St.</u>			
3. NAME OF DECEASED a. (First) <u>Louise</u>		b. (Middle) _____		(Last) <u>Gates</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>10-18-51</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>abt. 1876</u>	
9. AGE (In years last birthday) <u>73</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 4 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13a. FATHER'S NAME <u>William Hobbitt</u>		13b. MOTHER'S MAIDEN NAME <u>Phary Daner</u>	
14. NAME OF HUSBAND OR WIFE _____				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT'S (SIGNATURE OR NAME) <u>Glen Gates</u>				ADDRESS _____			
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) <u>Subdural hemorrhage</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>0</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>0</u>					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input 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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> _____		21f. HOW DID INJURY OCCUR? <u>331X</u>			
22. I hereby certify that I attended the deceased from <u>Oct 14 1951</u> , to <u>Oct 18, 1951</u> , that I last saw the deceased alive on <u>Oct 17, 1951</u> , and that death occurred at _____ m., from the causes and on the date stated above.							
23a. SIGNATURE <u>D. Earl Smith M.D.</u> (Degree or title)				23b. ADDRESS <u>1501 Madison St. Lovey Ill.</u>		23c. DATE SIGNED _____	
24a. BURIAL, CREMATION, REMOVAL <u>Removal</u>		24b. DATE <u>10/22/51</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Brooklark Heights</u>		24d. LOCATION (City, town, or county) (State) <u>Centerville Ill.</u>	
DATE REC'D BY LOCAL REG. <u>OCT 20 1951</u>		REGISTRAR'S SIGNATURE <u>D. Earl Smith M.D.</u>		FUNERAL DIRECTOR'S SIGNATURE <u>R.M.C. Jones</u>		ADDRESS <u>3517 LaSalle</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 *Edgar H Green*

Licensed Embalmer No. *4591*

P. O. Address *3517 LaSalle*

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.