

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38715

FILED DEC 1 1951

State File No. 10458  
Registrar's No.

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No. 10458		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____							
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>			c. LENGTH OF STAY (In this place) <b>4 yrs</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>			2219			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Homer G Phillips Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>3002 Lawton</b>							
3. NAME OF DECEASED (Type or Print) <b>Fred</b>			a. (First)		b. (Middle)		c. (Last) <b>Billups</b>				
4. DATE OF DEATH <b>Nov. 22 1951</b>		Month		Day		Year					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>9-26-1875</b>		9. AGE (In years last birthday) <b>76</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nil</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <b>Louisville, Miss.</b>			12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>				
13a. FATHER'S NAME <b>Andrew Billups</b>			13b. MOTHER'S MAIDEN NAME <b>Unknown</b>			14. NAME OF HUSBAND OR WIFE _____					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <b>Doll Armstrong</b> ADDRESS <b>3002 Lawton</b>							
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) <b>Cerebral Thrombosis</b>  ANTECEDENT CAUSES DUE TO (b) <b>Undetermined</b> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>None</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Undet.</b>	
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? <b>3324</b>									
22. I hereby certify that I attended the deceased from <b>11-15</b> , 19 <b>51</b> , to <b>11-22</b> , 19 <b>51</b> , that I last saw the deceased alive on <b>11-22</b> , 19 <b>51</b> , and that death occurred at <b>9:45 p. m.</b> , from the causes and on the date stated above.											
23a. SIGNATURE <b>Lorenzo W. Harris</b> (Degree or title) <b>M. D.</b>				23b. ADDRESS <b>2601 N Whittier St</b>			23c. DATE SIGNED <b>11-23-51</b>				
24a. BURIAL, CREMATION, REMOVAL _____		24b. DATE <b>11-24-51</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Marianas, Ark.</b>		24d. LOCATION (City, town, or county) (State) _____					
DATE REC'D BY LOCAL REG. _____		REGISTRAR'S SIGNATURE <b>Carl Smith</b>			25. FEDERAL DIRECTOR'S SIGNATURE <b>Shade Cranberry</b> ADDRESS <b>4202 Finney</b>						

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

*Melvin E. Green*

Licensed Embalmer No. *4428*

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.