

STANDARD CERTIFICATE OF DEATH

FILED DEC 1 1951

39752  
State File No. 10337  
Registrar's No. 10337

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (in this place) 40 yrs.		d. STREET ADDRESS (If rural, give location) 2607 North Taylor Street	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital			

3. NAME OF DECEASED (Type or Print) Lillie	a. (First)	b. (Middle)	c. (Last) Smith	4. DATE OF DEATH Nov. 16, 1951	(Month) (Day) (Year)
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5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH 12/25/1894	9. AGE (In years last birthday) 56	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY General House-	11. BIRTHPLACE (State or foreign country) Oxford, Mississippi /	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Nelson Myers	13b. MOTHER'S MAIDEN NAME Anna Mitchell	14. NAME OF HUSBAND OR WIFE Frank Smith
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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 Willa Mae Myers	ADDRESS 2617 N. Taylor
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Cardio Vascular Disease		Undetermined
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Undetermined DUE TO (c) Undetermined		
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 <input type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT (Specify) SUICIDE HOMICIDE	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR HHSX
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22. I hereby certify that I attended the deceased from Nov. 13, 1951, to Nov. 16, 1951, that I last saw the deceased alive on Nov. 16, 1951, and that death occurred at 8:08 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Lorena M. Harris M.D.	23b. ADDRESS 2601 N. Whittier St.	23c. DATE SIGNED Nov. 17, 1951
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11/24/51	24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
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DATE REC'D BY LOCAL REG. NOV 20 1951	REGISTRAR'S SIGNATURE Earl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE GATES FUNERAL HOME	ADDRESS Charles J. Gates, 4107 Finney Ave.
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(Licensed Embalmer's Statement on Reverse Side)

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.....

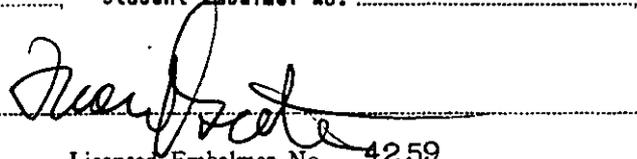
Student Embalmer No. ....

working under my personal supervision.

Student .....

Student Embalmer No. ....

Signed



Licensed Embalmer No. 4259

P. O. Address 4107 Finney Avenue

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.