

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39778

State File No. _____
Registrar's No. **10832**

FILED DEC 15 1951

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 4156a St. Ferdinand	

3. NAME OF DECEASED (Type or Print) Allen Stepps			4. DATE OF DEATH (Month) (Day) (Year) Dec. 2 1951		
5. SEX Male 2	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH April 16, 1900	9. AGE (In years last birthday) 51	10. UNDER 1 YEAR Months
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Window Cleaner		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) West Point, Mississippi		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Thomas Stepp	13b. MOTHER'S MAIDEN NAME Amanda Long	14. NAME OF HUSBAND OR WIFE Jerutha Stepp
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. 495-14-7099	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Jerutha Stepp, 4156A St. Ferdinand

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis		Undetermined		4 mos
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (b)		
ANTECEDENT CAUSES		DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS		Tuberculous Spondylitis (Lumbar 3 & 4)		
Conditions contributing to the death but not related to the disease or condition causing death.				
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION (Spinal Fusion)		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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 33 JXA

22. I hereby certify that I attended the deceased from **7-27-**, 19**51**, to **12-2-**, 19**51**, that I last saw the deceased alive on **12-2**, 19**51**, and that death occurred at **3 a** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Frank O. Richard M.D.	23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 12-3-51
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 7	24b. DATE 12/8/51	24c. NAME OF CEMETERY OR CREMATORY Washington Park Cem.
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE DEC 6 1951	24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.	24e. FUNERAL DIRECTOR'S SIGNATURE ADDRESS GATES FUNERAL HOME Charles J. Gates, 4107 Finney Avenue

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 _____

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.