

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42929

State File No.

FILED JAN 10 1952

318

1003

11026

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois		b. COUNTY St. Clair	
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 East St. Louis		8120	
c. LENGTH OF STAY (in this place) 2 wks		d. STREET ADDRESS (If rural, give location) 18 North 15th St.		8	
d. FULL NAME OF HOSPITAL OR INSTITUTION Peoples Hospital					

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) CREASIE		b. (Middle) FLOYD		c. (Last) FLOYD	
			Month		Day
			Dec. 11,		1951

5. SEX Female 3	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug 4, 1908	9. AGE (In years last birthday) 43	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Mississippi		12. CITIZEN OF WHAT COUNTRY? USA	
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13a. FATHER'S NAME William Mason		13b. MOTHER'S MAIDEN NAME Hattie Montgomery		14. NAME OF HUSBAND OR WIFE Lonzo Floyd	
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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. None		17. INFORMANT'S SIGNATURE OR NAME William Mason-18North 15th, E. St. Louis, Ill		ADDRESS	
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Uremia</i>				INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES					
		DUE TO (b) <i>Hypertension</i>					
		DUE TO (c) <i>Nephrosis</i>					
		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 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)	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>592X</i>	
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22. I hereby certify that I attended the deceased from *11:05*, 1951, to *12:00*, 1951, that I last saw the deceased alive on *12/11*, 1951, and that death occurred at *5:15* p.m., from the causes and on the date stated above.

22a. SIGNATURE <i>Edgar F. Woodson</i>		22b. ADDRESS <i>930 N 2nd St</i>		22c. DATE SIGNED <i>12/15/51</i>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Dec 13 1951		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) East St. Louis, Illinois	
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DATE REC'D. BY LOCAL REGISTERAR'S SIGNATURE <i>DEC 13 1951</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>J.L. Marshall</i>		ADDRESS J.L. Marshall Funeral Home, E. St. Louis, Ill.	
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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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed *Thomas M. Lubson*

Licensed Embalmer No. 4479

P. O. Address East St. Louis, Ill.

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.