

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6199

FILED FEB 27 1952

State File No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1107

1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>St. Louis</u>) OR TOWN <u>St. Louis</u> c. LENGTH OF STAY (In this place) _____ d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Homer G Phillips Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____ c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u> <u>2129</u> OR TOWN <u>St. Louis</u> d. STREET ADDRESS (If rural, give location) <u>4745 Lewis Pl.</u> <u>12</u>	
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3. NAME OF DECEASED (Type or Print) a. (First) <u>Dr. Frances</u> b. (Middle) <u>Edward</u> c. (Last) <u>Anthony</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Jan.</u> <u>31</u> <u>1952</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED <u>Married</u> (Specify)	8. DATE OF BIRTH <u>July 16, 1895</u>	9. AGE (In years last birthday) <u>56</u>	IF UNDER 1 YEAR Months <u>6</u>	IF UNDER 1 YEAR Days <u>15</u>	IF UNDER 1 HRS. Hours _____	IF UNDER 1 HRS. Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Denist</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>St. Genevieve, Mo.</u> <u>0</u>	12. CITIZEN OF WHAT COUNTRY? _____
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13a. FATHER'S NAME <u>David Anthony</u>	13b. MOTHER'S MAIDEN NAME <u>Mildred Virginia Harrison</u>	14. NAME OF HUSBAND OR WIFE <u>Cathrine Anthony</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>W. W. #1</u>	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>Cathrine Anthony</u> ADDRESS <u>4745 Lewis Pl.</u>
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Massive Gastro-intestinal Hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Esophageal Varices</u> DUE TO (c) <u>Cirrhosis of Liver</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>Undet.</u> <u>Undetermined</u>
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19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION _____	20. AUTOPSY? YES <input checked="" 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) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>5810</u>
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22. I hereby certify that I attended the deceased from 1-29, 1952, to 1-31, 1952, that I last saw the deceased alive on 1-31, 1952, and that death occurred at 3:50p m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>J. O. Richards</u> M. D.	23b. ADDRESS <u>2601 N Whittier St</u>	23c. DATE SIGNED <u>2-2-52</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) _____	24b. DATE <u>Feb. 5, 1952</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Washington Park</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>
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DATE REC'D BY LOCAL REG. <u>FEB 4 1952</u>	REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>J. H. Randle & Son</u> ADDRESS <u>3133 Bell Ave.</u>
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M.D. (Licensed Embalmer's Statement on Reverse Side)

WITH GREENLY-USE 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. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.