

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAR 5 1952

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State File No. 6215

1375

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 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) 4401 B. Evans Ave.	

3. NAME OF DECEASED (Type or Print) a. (First) Ida	b. (Middle) Bash	c. (Last) Bash	4. DATE OF DEATH (Month) (Day) (Year) 2-10 1952
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5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH March 22, 1883	9. AGE (In years last birthday) 68	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HOURS Hours	IF UNDER 24 HOURS Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Greene County, Mo	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Frank Bash	13b. MOTHER'S MAIDEN NAME Dayse Wilkes	14. NAME OF HUSBAND OR WIFE None
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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 Helen Sedric	ADDRESS 4401 B. Evans Ave.
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Undet.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Arteriosclerotic Heart Disease		
	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)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Uterine Fibroid			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? H200
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22. I hereby certify that I attended the deceased from **1-21**, 19**52**, to **2-10**, 19**52**, that I last saw the deceased alive on **2-10**, 19**52**, and that death occurred at **10:15pm.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Lorena W. Harris M. D.	23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 2-11-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 2/15/52	24c. NAME OF CEMETERY OR CREMATORY Washington Park Cem.	24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE FEB 13 1952 J. Earl Smith M.D. R.P.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C.W. Roberts 1416 N. Taylor Ave.
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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.....

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed.....

James A. Carter

Licensed Embalmer No. *4187*

P. O. Address *4923 Seehusman*

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.