

S. No. 300  
V. 10.48

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **14074**

FILED MAY 1 - 1952

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3616**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>	
c. LENGTH OF STAY (In this place) <b>Life</b>		d. STREET ADDRESS (If rural, give location) <b>4529a St. Ferdinand</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Homer G Phillips Hospital</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Sarah</b>	b. (Middle)	c. (Last) <b>Bracey</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>April 14 1952</b>
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5. SEX <b>3</b> <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>4/29/1919</b>	9. AGE (In years last birthday) <b>32</b>	10. MONTH <b>11</b>	11. DAY <b>15</b>	12. HOUR <b>1:55</b>	13. MILE <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>same</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Leonard Shelton</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah B. Green</b>	14. NAME OF HUSBAND OR WIFE <b>Wyatt H. Bracey</b>
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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) <b>no</b>	16. SOCIAL SECURITY NO. <b>unknown</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Wyatt H. Bracey</b>	ADDRESS <b>4529a St. Ferdinand</b>
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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 <b>Undet.</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Probable Renal Failure</b>		
	ANTECEDENT CAUSES DUE TO (b) <b>Etiology undetermined</b>		
DUE TO (c)		DUE TO (c) <b>None</b>	
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 <b>593 X</b>	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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **4-4-1952**, to **4-14-1952**, that I last saw the deceased alive on **4-14-1952**, and that death occurred at **12:55a** m., from the causes and on the date stated above.

22a. SIGNATURE <b>Carene M. Turner, D.</b>	(Degree or title)	23b. ADDRESS <b>2601 N Whittier</b>	23c. DATE SIGNED <b>4-15-52</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>4/18/52</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Washington Park Cem.</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>
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DATE REC'D BY LOCAL REG. <b>APR 17 1952</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>GATES FUNERAL HOME</b>	ADDRESS <b>Charles J. Gates, 4107 Finney Ave.</b>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

mjb (Licensed Embalmer's Statement on Reverse Side)

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.



Signed \_\_\_\_\_

Student .....  
Student Embalmer

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.