

FILED JUN 27 1952

THE DIVISION OF HEALTH OF THE STATE OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22014**
5266

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** 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 OR TOWN St. Louis		c. CITY OR TOWN Centerville Station #121	
c. LENGTH OF STAY (In this place) 5 days		d. STREET ADDRESS (If rural, give location) 4618 Russell	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Hattie b. (Middle) Gaines c. (Last) Gaines			4. DATE OF DEATH (Month) (Day) (Year) June 6 1952		
5. SEX 3 Female		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	
8. DATE OF BIRTH 1882 about 69 years			9. AGE (In years last birthday) 69 If under 1 year: Months _____ Days _____ If under 12 hrs: Hours _____ Mins _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (City and State or Foreign Country) Mississippi	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME unknown		13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE -----	
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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 Hattie Ellis	
				ADDRESS 4618 Russell	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Undet.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gastro-intestinal Bleeding		
	ANTECEDENT CAUSES DUE TO (b) Undetermined <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i>		
	DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Chronic Glomerulo-nephritis <i>Conditions contributing to the death but not related to the disease or condition causing death.</i>		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 578X		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? 578X	
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22. I hereby certify that I attended the deceased from **6-3-** 19**52**, to **6-6-** 19**52**, that I last saw the deceased alive on **6-6-** 19**52**, and that death occurred at **8:30a** m., from the causes and on the date stated above.

23a. SIGNATURE Larence W Harris M. D.		23b. ADDRESS 2601 N Whittier St.		23c. DATE SIGNED 6-9-52	
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24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 6-9-52		24c. NAME OF CEMETERY OR CREMATORY Booker Washington	
24d. LOCATION (City, town, or county) (State) E. St. Louis, Ill					

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JUN 9 1952 J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Rev. Nash		ADDRESS 3847 Page	
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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 M. Frances Nash

Licensed Embalmer No. 4434

P. O. Address 3847 Bay

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.