

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

State File No. **22521**
Registrar's No. **5737**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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 2119	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 2618 N Taylor	
3. NAME OF DECEASED (Type or Print) a. (First) Frances b. (Middle) Railey c. (Last) Railey		4. DATE OF DEATH (Month) (Day) (Year) June 18 1952	
5. SEX Female 3	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 19, 1890
9. AGE (In years last birthday) 62		10. MONTHS 1	11. DAYS 29
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Bonfield, Mo.
12. CITIZENSHIP OF WHAT COUNTRY? U. S. A.		13a. FATHER'S NAME Frederick Stewart	
13b. MOTHER'S MAIDEN NAME Mariah		14. NAME OF HUSBAND OR WIFE Cleave Railey	
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.	
17. INFORMANT'S SIGNATURE OR NAME Cleave Railey		ADDRESS	

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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Old Cerebral Vascular Disease ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last: DUE TO (b) _____ DUE TO (c) Heat Prostration		INTERVAL BETWEEN ONSET AND DEATH Undet.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION ooo	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)
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? E9219		

22. I hereby certify that I attended the deceased from **6-16**, 19**52**, to **6-18**, 19**52**, that I last saw the deceased alive on **6-18**, 19**52**, and that death occurred at **11:15a** m., from the causes and on the date stated above. **46**

23a. SIGNATURE (Degree or title) Edna E. Brooks, D.O.	23b. ADDRESS 2601 N Whittier St	23c. DATE SIGNED 6-18-52
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE June 23, 1952	24c. NAME OF CEMETERY OR CREMATORY Washington Park
24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.	25. EMERALD PRACTICE ADDRESS 3133 Bell Ave. 3133 Bell Ave.	

DATE REC'D BY LOCAL REG. **JUN 20 1952**
REGISTRAR'S SIGNATURE **J. Carl Smith**
ADDRESS **3133 Bell Ave.**

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

J. J. Johnston
.....
Licensed Embalmer No. *369 A*

P. O. Address *3769 d Houston*

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.