

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22777

State File No. _____

Registrar's No. **5397**

FILED JUN 27 1952

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) c. LENGTH OF STAY (in this place)
St. Louis **6 yrs.**
c. CITY (If outside corporate limits, write RURAL and give township)
St. Louis **2129**

d. FULL NAME OF HOSPITAL OR INSTITUTION **Peoples Hospital**
d. STREET ADDRESS (If rural, give location)
4591 Kensington Avenue

3. NAME OF DECEASED a. (First) **Dorothy** b. (Middle) **J.** c. (Last) **Wall**
4. DATE OF DEATH (Month) (Day) (Year)
6/9/52

5. SEX **Female** 6. COLOR OR RACE **Negro** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **Divorced** 8. DATE OF BIRTH **10/29/12**
9. AGE (in years last birthday) **39** IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **File Clerk**
10b. KIND OF BUSINESS OR INDUSTRY **Admin. Center**
11. BIRTHPLACE (State or foreign country) **Goldsboro, North Carolina**
12. CITIZEN OF WHAT COUNTRY? **USA**

13a. FATHER'S NAME **W.A. Jones** 13b. MOTHER'S MAIDEN NAME **Lillie Pearl McIntire** 14. NAME OF HUSBAND OR WIFE **William Wall**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No** (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. _____
17. INFORMANT'S SIGNATURE OR NAME **Lillie Jones** ADDRESS **4591 Kensington Ave.**

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Heart Disease
INTERVAL BETWEEN ONSET AND DEATH **4 months**
ANCECEDENT CAUSES
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. **DUE TO (b) None**
DUE TO (c) None
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION **NO** 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES NO

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 NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? **443X**

22. I hereby certify that I attended the deceased from **Feb. 11, 1952** to **June 9, 1952**, that I last saw the deceased alive on **6/4/52**, 19____, and that death occurred at **10:55 PM.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) **Alma Moore, M.D.** 23b. ADDRESS **4501a Easton** 23c. DATE SIGNED **6/11/52**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 24b. DATE **6/13/52** 24c. NAME OF CEMETERY OR CREMATORY _____ 24d. LOCATION (City, town, or county) (State) **Goldsboro, N. Carolina**

DATE REC'D BY LOCAL REG. **JUN 12 1952** REGISTRAR'S SIGNATURE **J. Carl Smith, M.D.** 25. FUNERAL DIRECTOR'S SIGNATURE **Chas. J. Gates** ADDRESS **4107 Finney Avenue**

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

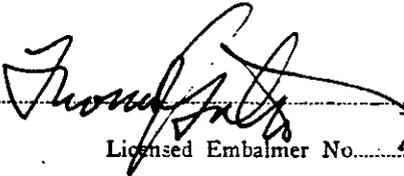
STATEMENT BY LICENSED EMBALMER

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  _____

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.