

FILED JUL 2 - 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 22785
Registrar's No. 5420

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, 2209	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If rural, give location) 20 1512 Elliot	
3. NAME OF DECEASED (Type or Print) a. (First) Mattie b. (Middle) c. (Last) Washington		4. DATE OF DEATH (Month) (Day) (Year) 6 8 52	
5. SEX 3 Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 9-1-1894
9. AGE (In years last birthday) 57		10. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) Housewife	11. BIRTHPLACE (City and State or Foreign Country) Paducah Kentucky
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Mike Thomas	
13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE Frank Washington	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Frank Washington		ADDRESS 1512 Elliot	
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.			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ANTECEDENT CAUSES Cardio Renal Vascular Disease DUE TO (b) Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
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	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 442X	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 1245 P.M. , from the causes and on the date stated above.			
23a. SIGNATURE (Deputy or title) Walter Perry Deputy Coroner		23b. ADDRESS 1300 Clark	23c. DATE SIGNED 6/10/52
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 6-13-52	24c. NAME OF CEMETERY OR CREMATORY Greenwood	24d. LOCATION (City, town, or county) (State) St. Louis Mo.
DATE REC'D BY LOCAL JUN 12 1952	REGISTRAR'S SIGNATURE Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Atkins Bros. 3644 Finney	

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

6-16-52

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

John K. Cunningham

Licensed Embalmer No. *4476*

P. O. Address *4223 Enright*

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.