

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

7318

FILED FEB 25 1953

State File No. ....

318

1003

Registrar's No. 1321

BIRTH NO. ....		REG. DIST. NO. ....		PRIMARY REG. DIST. NO. ....		Registrar's No. 1321			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY					
b. CITY OR TOWN St. Louis		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN St. Louis		2219			
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital				d. STREET ADDRESS (If rural, give location) 21 2816 Stoddard					
3. NAME OF DECEASED (Type or Print) Emma			a. (First)		b. (Middle)		c. (Last) Anderson		
4. DATE OF DEATH Jan. 30 1953		5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH July 4, 1875	
9. AGE (In years last birthday) 77		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mid-wife		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (City and State or Foreign Country) Mississippi		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME West Moss		13b. MOTHER'S MAIDEN NAME Louise Adams		14. NAME OF HUSBAND OR WIFE Deceased					
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 Mrs. Mary White 2816 Stoddard St.					
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.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Disease  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Undetermined DUE TO (c)  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None				INTERVAL BETWEEN ONSET AND DEATH Undet.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 334X					
22. I hereby certify that I attended the deceased from 5-23, 19 52, to 1-30, 19 53, that I last saw the deceased alive on 1-30, 19 53 and that death occurred at 3:15 p. m., from the causes and on the date stated above.									
23a. SIGNATURE Charles P. Ford M. D.				23b. ADDRESS 2601 N Whittier St		23c. DATE SIGNED 2-2-53			
24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 2-7-53		24c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri			
DATE REC'D BY LOCAL REG. FEB 4 1953		REGISTRAR'S SIGNATURE Paul Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ellis Funeral Home, Inc. 2820 Stoddard St					

(Licensed Embalmer's Statement on Reverse Side)

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

FEB 25 1953

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

*Foster E. Culkin*

Licensed Embalmer No. *4198*

P. O. Address

*St Louis 13*

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.