

FILED MAY 18 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **20045**
Registrar's No. **4467**

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	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital		d. STREET ADDRESS (If rural, give location) 2623 Pine St	

3. NAME OF DECEASED (Type or Print) a. (First) Rebecca b. (Middle) c. (Last) West		4. DATE OF DEATH (Month) (Day) (Year) April 29, 1953	
5. SEX 3 Female	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH March 2, 1897
9. AGE (In years last birthday) 56		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	11. BIRTHPLACE (State or foreign country) Unknown
12. CITIZEN OF WHAT COUNTRY? USA			

13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Sarah Murphy	14. NAME OF HUSBAND OR WIFE Deceased
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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.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Rebecca Jackson 1800 N. Leffingwell Ave.
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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, ashenia, 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) Cerebral Thrombosis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertensive Cardiovascular Disease DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Uterine Myoma			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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)
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? 443X

22. I hereby certify that I attended the deceased from **4-11**, 19 **53**, to **4-29**, 19 **53**, that I last saw the deceased alive on **4-29**, 19 **53**, and that death occurred at **8:15a** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Edna E. Brooks M. D.	23b. ADDRESS 2601 N Whittier St.	23c. DATE SIGNED 4-29-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) removal	24b. DATE 5-4-53	24c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri
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DATE REC'D BY LOCAL REG. MAY 1 1953	REGISTRAR'S SIGNATURE Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ellis Funeral Home, Inc. 2820 Stoddard St.
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADEING 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 H. E. Culkin

Licensed Embalmer No. 4198

P. O. Address St Louis Mo

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.