

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6947**
Registrar's No. **1837**

BIRTH NO. **FILED MAR 8 1954** 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 OR TOWN St. Louis	d. Is Residence within limits of a city incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION 2927 Garrison Court		e. STREET ADDRESS (If rural, give location) 2927 Garrison Court	
3. NAME OF DECEASED (Type or Print)		a. (First) Lula	b. (Middle)
		c. (Last) Ware	4. DATE OF DEATH (Month) (Day) (Year) 2 23 54
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 2-15-1893
9. AGE (In years last birthday) 61		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundress	11. BIRTHPLACE (City and State or Foreign Country) Lake Providence, La.
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Hence Stevenson	13b. MOTHER'S MAIDEN NAME Caroline Turner
14. NAME OF HUSBAND OR WIFE Edward Ware		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME Pink Stevenson		ADDRESS 10a So. Ewing	
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) Cerebral Apoplexy(stroke) and Hypertensive 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) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Nephritis.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION None	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) None	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? 443X	
22. I hereby certify that I attended the deceased from 8/2 , 19 53 , to 2/15/54 , 19____, that I last saw the deceased alive on 2/15/54 , and that death occurred at 7:40 Pm. , from the causes and on the date stated above.			
23a. SIGNATURE [Signature] (Degree or title)		23b. ADDRESS 2918a Market.	23c. DATE SIGNED 2/25/54
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 2-27-54	24c. NAME OF CEMETERY OR CREMATORY Father Dickson	24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
DATE REC'D BY LOCAL REG. FEB 26 1954	REGISTRAR'S SIGNATURE J. Earl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Russell Und., Co. 2732 Pine Bl.	

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.....
Signature of Student Embalmer

Signed *James A. Carter*

Licensed Embalmer No. *1160*

P. O. Address *St. Louis*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.