

FILED SEP 2 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28927
Registrar's No. 7504

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No. 28927		Registrar's No. 7504				
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. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>					
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital				e. STREET ADDRESS (If rural, give location) 21 3005 Pine Street		2219						
3. NAME OF DECEASED (Type or Print) Annie Green			a. (First)		b. (Middle)		c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) August 8, 1954			
5. SEX F 3		6. COLOR OR RACE C		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW		8. DATE OF BIRTH NOV 6 1907		9. AGE (In years last birthday) 46		10. IF UNDER 1 YEAR Days 8	11. IF UNDER 4 HRS. Hours _____	12. IF UNDER 15 MIN. Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) GRACES MISS			12. CITIZEN OF WHAT COUNTRY? _____			
13a. FATHER'S NAME MOSC WILLIAMS			13b. MOTHER'S MAIDEN NAME JENNER TURNER			14. NAME OF HUSBAND OR WIFE WIDOW						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS MAGGIE DAWSON 3009 Pine								
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) Hypertensive Cardiovascular Disease with Decompensation INTERVAL BETWEEN ONSET AND DEATH Undt ANTECEDENT CAUSES DUE TO (b) _____ Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
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) 443 X								
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? _____								
22. I hereby certify that I attended the deceased from July 26, 1954, to August 8, 1954, that I last saw the deceased alive on August 8, 1954, and that death occurred at 8:40 a.m., from the causes and on the date stated above.												
23a. SIGNATURE (Degree or title) E. B. Williams M.D.				23b. ADDRESS 2601 N. Whittier				23c. DATE SIGNED 8/9/54				
24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE 8-14-54		24c. NAME OF CEMETERY OR CREMATORY GREENWOOD		24d. LOCATION (City, town, or county) (State) WELLESLEY MO						
DATE REC'D BY LOCAL REG. AUG 13 1954		REGISTRAR'S SIGNATURE J. C. Smith			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS A. F. Walter 2707 Stoddard							

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 *W. Claude Gordon*.....

Licensed Embalmer No. *348*

P. O. Address *4575 B*

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.