

FILED OCT 14 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32464**
Registrar's No. **2303**

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **541**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO COUNTY St. Louis	
b. CITY (If outside corporate limits of St. Louis and St. Charles) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION County Hospital		STREET ADDRESS (If rural, give location) Freeland Ave.	

3. NAME OF DECEASED (Type or Print) Arthur Washington			4. DATE OF DEATH (Month) (Day) (Year) 9 24 54		
5. SEX Male		6. COLOR OR RACE NEGRO		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	
8. DATE OF BIRTH Sept 11, 1901		9. AGE (In years last birthday) 53		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stacked lumber		10b. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (City and State or Foreign Country) Mississippi	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME Eddie Washington		13b. MOTHER'S MAIDEN NAME unk.		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. unk.		17. INFORMANT'S SIGNATURE OR NAME Arthur Washington Jr.	
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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) Pulmonary Embolus, left lung		INTERVAL BETWEEN ONSET AND DEATH few min	
		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. Cerebral Hemorrhage, right			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 465X		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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?	

22. I hereby certify that I attended the deceased from **8-29, 1954** to **9-24, 1954**, that I last saw the deceased alive on **9-24-54**, and that death occurred at **9:10 P.m.**, from the causes and on the date stated above.

23a. SIGNATURE Cooper Gray, M.D. (Degree or title)		23b. ADDRESS 601 So. Brentwood		23c. DATE SIGNED 9-25-54	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10 1 1954		24c. NAME OF CEMETERY OR CREMATORY Oakdale	
				24d. LOCATION (City, town, or county) (State) Lemay MO	

DATE REC'D BY LOCAL REG. 10/1/54		REGISTRAR'S SIGNATURE Hebeal R. Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS R. H. Buehler 3506 Franklin	
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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 *Leroy W. Gannister*

Licensed Embalmer No. *452*

P. O. Address *3880 Cas*

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.