

FILED APR 14 1955

 THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

9454

State File No. ....

318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 2946

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <b>St. Louis</b>		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 <b>Homer G. Phillips Hospital</b>				STREET ADDRESS (If rural, give location) <b>2516 Belle Glade</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Annie</b>		b. (Middle) <b>Mae</b>		c. (Last) <b>Clemons</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>3 28 55</b>	
5. SEX <b>3</b> <b>FEMALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>12-7-1911</b>	
9. AGE (In years last birthday) <b>43</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____		11. BIRTHPLACE (City and State or Foreign Country) <b>ALA.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY _____		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <b>CAMPBELL WELLS</b>			13b. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			14. NAME OF HUSBAND OR WIFE <b>MR ALTHA CLEMONS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>MR. ALTHA CLEMONS 2516 BELLEGLADE</b>			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Diabetes Mellitus; Cerebral Thrombosis</b>  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. <b>Diabetic Coma</b>				INTERVAL BETWEEN ONSET AND DEATH <b>Undt.</b>	
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) _____		21f. HOW DID INJURY OCCUR? <b>260x</b>	
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"/>					
22. I hereby certify that I attended the deceased from <b>3-21</b> , 19 <b>55</b> , to <b>3-28</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>3-28</b> , 19 <b>55</b> , and that death occurred at <b>11:50P</b> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Edw. B. Williams</b> M.D.				23b. ADDRESS <b>2601 N. Whittier</b>		23c. DATE SIGNED <b>3-29-55</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		24b. DATE <b>4-4-55</b>		24c. NAME OF CEMETERY OR CREMATORY <b>NATIONAL</b>		24d. LOCATION (City, town, or county) (State) <b>JEFFERSON BARRICKS MO</b>	
DATE REC'D BY LOCAL REG. <b>APR 1 1955</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>PRICE FUNERAL HOME 2829 Washington Blvd.</b>			

(Licensed Embalmer's Statement on Reverse Side)

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.....  
*H. Claude Good*

Licensed Embalmer No. 348

P. O. Address 4575 A11

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.