

FILED AUG 2 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24368
State File No.
6035

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO. 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 2916^a Delman		e. STREET ADDRESS (If rural, give location) 21 2916^a Delman 22190	
3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) c. (Last) Sherard		4. DATE OF DEATH (Month) (Day) (Year) July 7, 1955	
5. SEX F	6. COLOR OR RACE Col.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widow	8. DATE OF BIRTH Sept 6, 1873
9. AGE (in years last birthday) 81	if under 1 year Months	if under 1 year Days	if under 1 year Hours 5 Mins 15
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State Foreign Country) Miss		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Wm Griffin		13b. MOTHER'S MAIDEN NAME Eliza Ward	14. NAME OF HUSBAND OR WIFE Lillie Morgan
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Lillie Morgan 2916^a Delman	
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertension 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.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)	
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? 474X	
22. I hereby certify that I attended the deceased from June 1, 1955 , to July 9, 1955 , that I last saw the deceased alive on July 7, 1955 , and that death occurred at 2 P. m. , from the causes and on the date stated above.			
23a. SIGNATURE Walter A Young		23b. ADDRESS 2337 Market St. St. Louis Mo	23c. DATE SIGNED 7/11/55
24a. BURIAL CREMATION, REMOVAL (Specify) burial	24b. DATE July 13/55	24c. NAME OF CEMETERY OR CREMATORY Washington Park Cem St. Louis	24d. LOCATION (City, town, or county) (State) Mo
DATE REC'D BY LOCAL REG. Jul 13 1955		REGISTRAR'S SIGNATURE J. Carl Smith	25. SHERIFF'S SIGNATURE ADDRESS F. A. Green 4214 Delman

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 *F. A. Gear*

Licensed Embalmer No. *2963*
P. O. Address *4214 Selma*

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.