

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **34789**
8973

FILED OCT 24 1955

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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 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 119a^N Compton Ave.				e. STREET ADDRESS (If rural, give location) 21 119a^N Compton Ave.			
3. NAME OF DECEASED (Type or Print) a. (First) Sarah		b. (Middle) _____		c. (Last) Greenleaf		4. DATE OF DEATH (Month) (Day) (Year) 10-10-55	
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH July 15, 1893	
9. AGE (In years last birthday) 62		IF UNDER 1 YEAR: Months _____ Days _____		IF UNDER 1 HRS. Hour _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) Columbus, Miss.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Issac Jones		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE William Greenleaf			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS William Greenleaf 119a Compton			
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) Myocardial Infarction ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 4201				INTERVAL BETWEEN ONSET AND DEATH _____	
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) 4201			
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 May 1, 1955 , to Oct 10, 1955 , that I last saw the deceased alive on Oct 10, 1955 , and that death occurred at 3 P. m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Walter G. Young M.D.				23b. ADDRESS 2337 Market St. Mo.		23c. DATE SIGNED 10.12.55	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10-15-55		24c. NAME OF CEMETERY OR CREMATORY Washington Pk. Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County, MO.	
DATE REC'D BY LOCAL REG. OCT 14 1955		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Price Ben. Of Friends 2829 Washington			

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFAADING 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 *Walter R. Williams*

Licensed Embalmer No. *49*
4554 Lexington
P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F 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.