

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JUN 29 1956

State File No. **21728**  
Registrar's No. **5883**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>5883</b>	
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 town(ship)) 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>				e. STREET ADDRESS (If rural, give location) <b>21 2730 Gamble</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Rosa</b>			b. (Middle) _____			c. (Last) <b>Chatman</b>	
4. DATE OF DEATH (Month) (Day) (Year) <b>6 17 56</b>		5. SEX <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>Jan 2nd 1897</b>		9. AGE (In years last birthday) <b>59</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <b>Brinkville Mo ss.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S. A.</b>	
13a. FATHER'S NAME <b>Gabe Payne</b>		13b. MOTHER'S MAIDEN NAME <b>Sealy ?</b>		14. NAME OF HUSBAND OR WIFE <b>Clarence Chatman</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Clarence Chatman 2730 Gamble</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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cardiovascular Accident with Left Hemoplegia</b> ANTECEDENT CAUSES <b>Due to (b) Thrombosis</b> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <b>Undet.</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) <b>342 2:1</b>			
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 <b>6-9-</b> , 19 <b>56</b> , to <b>6-17-</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>6-17-</b> , 19 <b>56</b> , and that death occurred at <b>8:55 a.m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Edward B. Williams, M.D.</b>				23b. ADDRESS <b>2601 North Whittier</b>		23c. DATE SIGNED <b>6-20-56</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>6-22-56</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>		24d. LOCATION (City, town, or county) (State) <b>St Louis, Mo</b>	
DATE REC'D BY LOCAL REG. <b>JUN 21 1956</b>		REGISTRAR'S SIGNATURE <b>Paul Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>A. L. Beal Und. Co 4303 Delmar</b>			

WRITE PLAINLY—USING UNFAADING BLACK INK—MAKE A PERMANENT RECORD

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**STATEMENT BY LICENSED EMBALMER**

1911

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 H. Sannist*

Licensed Embalmer No. *452*

P. O. Address *2616 York*

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.