

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

6708

FILED FEB 25 1957

STATE FILE NUMBER 996

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) 1909 Belleglade	
3. NAME OF DECEASED (Type or print) First ADDIE Middle LEE Last TYLER		4. DATE OF DEATH Month Day Year JAN. 28, 1957	
5. SEX 3 Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 6, 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years last birthday) 67
13. FATHER'S NAME William Wilford		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No --		14. MOTHER'S MAIDEN NAME Robnett Poston	11. BIRTHPLACE (City and state or country) Cadiz, Kentucky
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Mack Tyler (husband) 1909 Belleglade	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA SUB-ACUTE GLOMERULONEPHRITIS DUE TO (b) 591x DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 7-8 WKS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour' - Month, Day, Year a. m. p. m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Sept. 19, 1955 to JAN. 28, 1957 and last saw her alive on JAN. 28, 1957. Death occurred at 4:00 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) C. D. Vermillion, M. D.		22b. ADDRESS BARNES HOSPITAL	
		22c. DATE SIGNED 1/29/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23d. LOCATION (City, town, or county) (State) Washington Park Cemetery St. Louis County, Mo.	
23b. DATE Feb. 4, 1957		23c. NAME OF CEMETERY OR CREMATORY	
24. FUNERAL DIRECTOR Charles J. Gates, 4107 Finney		25. DATE RECD. BY LOCAL REG. JAN 31 '57	
		26. REGISTRAR'S SIGNATURE J. Carl Smith mo	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE. Coroner cannot certify to a death due to natural causes. Diseases in Part I must be casually related. Doctor, coroner, etc. must use only black ink or ribbon type.

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.....  
Licensed Embalmer No. 182

P. O. Address 4107 Finne

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