

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

108227  
STATE FILE NUMBER  
1832  
Registrar's No.

FILED MAR 18 1957

Registration District No. 318 Primary Registration District No. 1003

|  |                           |   |  |  |   |   |  |
|--|---------------------------|---|--|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |                           |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE Missouri b. COUNTY |   |   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN St. Louis, Missouri   |                           |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                    |  | c. CITY OR TOWN St. Louis   |   | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION St. Mary's Infirmary  |                           |   | Length of stay in lb   |  | d. STREET ADDRESS (If outside, give location)<br>221 2820 Stoddard Street |   | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>Lucille E. Jones Norwood   |                           |   |  | 4. DATE OF DEATH<br>Month Day Year<br>2 20 1957  |   |   |  |
| 5. SEX<br>Female 3   | 6. COLOR OR RACE<br>Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>May 27, 1907   | 9. AGE (In years last birthday)<br>49  | IF UNDER 1 YEAR<br>Months Days Hours Min.                                 | IF UNDER 24 HRS.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Self-Employed   |                           | 10b. KIND OF BUSINESS OR INDUSTRY<br>Funeral Business   |  | 11. BIRTHPLACE (City and state or country)<br>McMinnville, Tennessee   |   | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |
| 13. FATHER'S NAME<br>Charles Roach   |                           |   |  | 14. MOTHER'S MAIDEN NAME<br>Fannie Ramsey  |   |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>No None   |                           | 16. SOCIAL SECURITY NO.<br>—  |  | 17. INFORMANT Address<br>John Norwood 2820 Stoddard Street   |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Cerebral Thrombosis<br>Essential Hypertension<br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.<br>DUE TO (b)<br>DUE TO (c) |                           |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br>2 mos. int<br>next one 10 days<br>Unknown                     |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>332x  |                           |   |  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" 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<br>Hour Month, Day, Year<br>a. m. p. m.  |                           |   |  |  |   |   |  |
| 20d. INJURY OCCURRED<br>WHILE AT <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<br>COUNTY STATE   |   |   |  |
| 21. I attended the deceased from Jan, 1957, to Feb 20, 1957 and last saw her alive on 2-19-57<br>Death occurred at 3:20 p. m. on the date stated above; and to the best of my knowledge, from the causes stated.   |                           |   |  |  |   |   |  |
| 22a. SIGNATURE (Degree or title)<br>J. Carl Smith, M.D.  |                           |   |  | 22b. ADDRESS<br>111 Jefferson St. St. Louis  |   | 22c. DATE SIGNED<br>2-23-57   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Removal   |                           | 23b. DATE<br>2/26/57  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Washington Park Cemetery   |   | 23d. LOCATION (City, town, or county) (State)<br>St. Louis County, Missouri                       |  |
| 24. FUNERAL DIRECTOR<br>C.W. Roberts and Co. 1416 N. Taylor Ave.   |                           |   | 25. DATE RECD. BY LOCAL REG.<br>FEB 23 '57   |  | 26. REGISTRAR'S SIGNATURE<br>J. Carl Smith M.D.<br>S.P.                   |   |  |

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 *Melvin E. Green* .....

Licensed Embalmer No. *447*

P. O. Address *St. Louis*

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.