

FILED JUN 26 1957

THE DIVISION OF HEALTH - MISSOURI  
STANDARD CERTIFICATE OF DEATH57 022504  
STATE FILE NUMBER  
3757

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		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN ST. LOUIS		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		Length of stay in lb		d. STREET ADDRESS 3510 Bell		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mamie Foster				4. DATE OF DEATH Month 6 Day 15 Year 57			
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 17, 1906 46	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home wife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Ala.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Ezekiel Meadows				14. MOTHER'S MAIDEN NAME Rachel ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Ann DeMan 3420 Kennedy			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage  Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Hypertension, Suspected DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Cardiovascular Disease 331X							INTERVAL BETWEEN ONSET AND DEATH  undet.
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 6-4-57 to 6-15-57 and last saw her alive on 6-15-57 Death occurred at 4:20 A m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Hugh Waters, M.D.			22b. ADDRESS 2601 Whittier Street			22c. DATE SIGNED 6-17-57	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 6-26-57		23c. NAME OF CEMETERY OR CREMATORY Washington Park		23d. LOCATION (City, town, or county) (State) St. Louis MO	
24. FUNERAL DIRECTOR F. G. Green 4214 DeMan			25. DATE RECD. BY LOCAL REG. JUN 20 '57		26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. S. P.		

(Licensed Embalmer's Statement on Reverse Side)

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Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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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. G. Green* \_\_\_\_\_

Licensed Embalmer No. *296*  
P. O. Address *4214 Delm*

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.