ealth,
Welfare
ublic
ervice

2009

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED FEB 14 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 3751

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1265

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo. Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer Phillips Length of stay in 1b 27 22/10

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY
c. CITY OR TOWN St. Louis Inside Limits Yes ☐ No ☐
d. STREET ADDRESS 3437a Franklin (If outside, give location) Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: Evie Middle: Last: Walker

4. DATE OF DEATH Month: Jan. Day: 30 Year: 1958

5. SEX Female 3

6. COLOR OR RACE Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH June 19, 1901

9. AGE (In years last birthday) 56

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) Housewife

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (City and state or country) Aberdeen, Miss.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Monroe Caruthers

14. MOTHER'S MAIDEN NAME Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. None

17. INFORMANT Address: Mrs. Sarah Hudson 3437 Franklin Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH

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)
DUE TO (c) 331h

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 ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 _____, to _____ and last saw her/him alive on _____
Death occurred at 7:45 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE James M Kelly (Degree or title) Deputy Coroner

22b. ADDRESS 1300 Clark

22c. DATE SIGNED 2-3-58

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal

23b. DATE 2/5/58

23c. NAME OF CEMETERY OR CREMATORY Oak Dale Cemetery

23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.

24. FUNERAL DIRECTOR G. Wade Granberry ADDRESS 4202 Finney

25. DATE RECD. BY LOCAL REG. FEB 3 '58

26. REGISTRAR'S SIGNATURE J Carl Smith MD
MDB

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Edward A. Flynn

Licensed Embalmer No. 4444

P. O. Address 4202 Finney

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.