

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-015490

STATE FILE NUMBER

4284

FILED APR 25 1958

318

1003

Registration District No.

Primary Registration District No.

Registrar's No.

5. 300  
1-57

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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |                                  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY  |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR<br>TOWN <b>St. Louis</b>  |                                  | Inside Limits<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  | c. CITY<br>OR<br>TOWN  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR<br>INSTITUTION <b>Homer G. Phillips</b>  |                                  | Length of stay in 1b   | d. STREET ADDRESS (If outside, give location)<br><b>4546a North Market</b>                                 |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Alma</b> Middle Last <b>Austin</b>  |                                  | 4. DATE OF DEATH<br>Month <b>4</b> Day <b>17</b> Year <b>58</b>  |  |
| 5. SEX<br><b>Female</b> <b>3</b>  | 6. COLOR OR RACE<br><b>Negro</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> <b>2</b> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Oct. 5, 1892</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  | 9. AGE (In years last birthday) <b>65</b><br>F UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.     |
| 11. BIRTHPLACE (City and state or country)<br><b>Miss.</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13a. FATHER'S NAME<br><b>Frank Seals</b>  |                                  | 13b. MOTHER'S MAIDEN NAME<br><b>Louisa Seals</b>   |  |
| 14. NAME OF HUSBAND OR WIFE   |                                  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  |
| 16. SOCIAL SECURITY NO.   |                                  | 17. INFORMANT<br><b>Dorothy Payne 4546a N. Market</b>  |  |
| 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) <b>CEREBRAL THROMBOSIS</b><br>Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>CEREBRAL ARTERIOSCLEROSIS</b><br>DUE TO (c) <b>332x</b> |                                  |  | INTERVAL BETWEEN ONSET AND DEATH   |
| 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? <b>2</b><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 a.m. Month, Day, Year 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 <b>4-4-58</b> to <b>4-17-58</b> and last saw her alive on <b>4-17-58</b><br>Death occurred at <b>8:33</b> <b>P</b> m on the date stated above; and to the best of my knowledge, from the causes stated.  |                                  |  |  |
| 22a. SIGNATURE<br><b>Paul M. Lamm</b> (Degree or title) <b>, M.D.</b>   |                                  | 22b. ADDRESS<br><b>2601 Whittier Street</b>  |  |
| 22c. DATE SIGNED<br><b>4-18-58</b>  |                                  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |                                  | 23b. DATE<br><b>April 21, 1958</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Washington Park Cem.</b>   |                                  | 23d. LOCATION (City, town, or county) (State)<br><b>St. Louis County, Mo.</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Reliable Funeral Sys, Inc. 1389N. Union</b>  |                                  | 25. DATE RECD. BY LOCAL REG.<br><b>APR 19 '58</b>  |  |
| 26. REGISTRAR'S SIGNATURE<br><b>J. Earl Smith - M.D.</b>  |                                  |  |  |

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 *Paul V. Freeman*

Licensed Embalmer No. *4686*  
P. O. Address *4729 Alameda*

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.