

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-019450  
State File No. ....

FILED JUN 13 1958

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 5906

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		a. STATE Missouri b. COUNTY	
c. LENGTH OF STAY (in this place)		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3/ St. Louis State Hospital		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) a. (First) Vester b. (Middle) c. (Last) Avants		e. STREET ADDRESS (If rural, give location) 5400 Arsenal St.	
4. DATE OF DEATH June 8, 1958		5. SEX Female 3	
6. COLOR OR RACE Negroid		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH April 27, 1907		9. AGE (In years last birthday) 51	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hotel maid		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (City and State or Foreign Country) Forest City, Arkansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Collins		13b. MOTHER'S MAIDEN NAME Hattie Winters Winfield	
14. NAME OF HUSBAND OR WIFE Albert Avants		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. 493-24-5224		17. INFORMANT'S SIGNATURE OR NAME Albert Avant 4022 Evans Ave	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Auricular fibrillation ANTECEDENT CAUSES DUE TO (b) Cardiac decompensation DUE TO (c) Rheumatic heart disease II. OTHER SIGNIFICANT CONDITIONS Chronic Brain Syndrome associated with circulatory disturbance	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 4/6x	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify)	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		22. I hereby certify that I attended the deceased from April 28, 1958, to June 8, 1958, that I last saw the deceased alive on June 8, 1958, and that death occurred at 4:05 a.m., from the causes and on the date stated above.	
23a. SIGNATURE Cecilia Aycock		23b. ADDRESS 5400 Arsenal St., St. Louis	
23c. DATE SIGNED 6-8-59		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE 6/13/58		24c. NAME OF CEMETERY OR CREMATORY Greenwood	
24d. LOCATION (City, town, or county) (State) 6571 St. Louis Ave		25. FUNERAL DIRECTOR'S SIGNATURE Boyd Bros 3706 Finney Ave	
DATE REC'D BY LOCAL REG. JUN 9 58		REGISTRAR'S SIGNATURE Carl Smith MD	

**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 *E. Edward J. Flynn*.....

Licensed Embalmer No... 4444.....

P. O. Address.... St. Louis. MO

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.