Health, Welfare Public Service

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-002657

STATE FILE NUMBER 2 935

FILED FEB 10 1959

Registration District No. ..... Primary Registration District No. ..... Registrar's No. .....

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

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 (If outside, give location): 2189 2930a Market — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Ella — Middle: — Last: Adams

4. DATE OF DEATH: Month 1 — Day 24 — Year 59

5. SEX: Female 3

6. COLOR OR RACE: Negro

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ 2 **DIVORCED** ☐

8. DATE OF BIRTH: 10-21-1900

9. AGE (In years last birthday): 58 — 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): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: unemployed

11. BIRTHPLACE (City and state or country): Mississippi

12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: John McClatchie

13b. MOTHER'S MAIDEN NAME: unknown

14. NAME OF HUSBAND OR WIFE: - -

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 490-12-2473

17. INFORMANT: Luther Bright — Address: 2930a Market St.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Uremia	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Kidney Failure	
DUE TO (c)	Hypertensive Cardiovascular Disease	undet.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): 443

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 1-20-59, to 1-24-59 and last saw her alive on 1-24-59
Death occurred at 8:20 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Paul H. Larson, M.D.

22b. ADDRESS: 2601 Whittier Street

22c. DATE SIGNED: 1-27-59

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

23b. DATE: 1-31-59

23c. NAME OF CEMETERY OR CREMATORY: Greenwood Cemetery

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

24. FUNERAL DIRECTOR: Atkins Bros. — ADDRESS: 3644 Finney Ave.

25. DATE RECD. BY LOCAL REG.: JAN 27'59

26. REGISTRAR'S SIGNATURE: Earl 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 embalmed by me, or by ....., Student Embalmer No. ..... working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed .....

Licensed Embalmer No. 4476

P. O. Address .....

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.