

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

79-011313  
STATE FILE NO.  
2 2517  
REGISTRATION NO.

FILED MAR 25 1958 Registration District No. Primary Registration District No. Registrar No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis State</b>		Length of stay in 1b <b>Over 2 mos.</b>	d. STREET ADDRESS (If outside, give location) <b>2907 Easton</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <b>Fannie</b> Middle <b>Richardson</b> Last			4. DATE OF DEATH Month <b>March</b> Day <b>8</b> Year <b>1959</b>		
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5. SEX <b>Female</b> <b>3</b>	6. COLOR OR RACE <b>Negroid</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> & DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 17, 1898</b>	9. AGE (In years last birthday) <b>60</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>West Point, Mississippi</b>	12. CITIZEN OF WHAT COUNTRY? <b>US</b>
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13a. FATHER'S NAME <b>Lemon Griffith</b>	13b. MOTHER'S MAIDEN NAME <b>Melvina Hunter</b>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>	16. SOCIAL SECURITY NO.	17. INFORMANT <b>Wm Howard</b> Address <b>2907 Easton</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> <b>Hypertensive heart disease</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Generalized arteriosclerosis</b> <b>443x</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>C.V.A. with Lt. hemiplegia (June 58) pyelo nephritis with anemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>
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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.)
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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
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21. I attended the deceased from <b>Dec. 1, 1958</b> , to <b>March 8, 1959</b> and last saw her alive on <b>March 8, 1959</b> Death occurred at <b>11:00 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <b>A J Heuster M.D.</b> (Degree or title)	22b. ADDRESS <b>5400 Arsenal St., St. Louis</b>	22c. DATE SIGNED <b>3-9-59</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>14 March 1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Father Dickman</b>	23d. LOCATION (City, town, or county) (Specify) <b>St Louis Co Mo</b>
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24. FUNERAL DIRECTOR <b>Relebe Funeral Svc</b> ADDRESS <b>1789 N Union</b>	25. DATE RECD. BY LOCAL REG. <b>MAR 11 '59</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith, M.D.</b>
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(Licensed Embalmer's Statement on Reverse Side)

300  
-57  
1  
192  
0

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *John K. Cummins* .....

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.