THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-019791
STATE FILE NUMBER

FILED MAY 26 1959 Registration District No. _____ Primary Registration District No. _____ Registrar's No. 24667

1. PLACE OF DEATH
a. COUNTY
b. CITY 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): 5540 Vernon — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Adline — Middle: — Last: Winston

4. DATE OF DEATH: Month 5 — Day 10 — Year 59

5. SEX: Female 3

6. COLOR OR RACE: Negro 3

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

8. DATE OF BIRTH: Dec 24 1868

9. AGE (In years last birthday): 90 — 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): Nil

10b. KIND OF BUSINESS OR INDUSTRY

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

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

13a. FATHER'S NAME: Sam Ford

13b. MOTHER'S MAIDEN NAME: Susie Ford?

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.: —

17. INFORMANT: Mattie Verner — Address: 5440 Vernon

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: undet.

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 331X

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

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 5-1-59, to 5-10-59 and last saw her alive on 5-10-59
Death occurred at 1:35 A m on the date stated above; and to the best of my knowledge, from the causes stated.

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

22b. ADDRESS: 2601 Whittier Street

22c. DATE SIGNED: 5-11-59

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

23b. DATE: May 14/59

23c. NAME OF CEMETERY OR CREMATORY: Father Dickson

23d. LOCATION (City, town, or county) (State): St Louis Co, MO

24. FUNERAL DIRECTOR: F. G. Green — **ADDRESS**: 4214 Delmar

25. DATE RECD. BY LOCAL REG.: MAY 13 '59

26. REGISTRAR'S SIGNATURE: Karl Smith, M.D. C.O.

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

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

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

working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed F. A. Green

Licensed Embalmer No. 2963

P. O. Address 4214 Delma

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.