

FILED VS MAY 3 1 1960

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

=60-021918

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1622

V. S. 300
 Rev. 1-57

1. PLACE OF DEATH a. COUNTY St. Louis CO		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Robertson		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Robertson 40002
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION NONE 90		Length of stay in lb YRS	d. STREET ADDRESS (If outside, give location) 35H HALL AVE
3. NAME OF DECEASED (Type or print) First LILLY Middle CRAIG Last			4. DATE OF DEATH Month 5 Day 19 Year 60
5. SEX Female	6. COLOR OR RACE 3 NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-2-1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home wife		10b. KIND OF BUSINESS OR INDUSTRY none	9. AGE (In years at last birthday) 78
11. BIRTHPLACE (City and state or country) JACKSON MISSI		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Edde McCORA		13b. MOTHER'S MAIDEN NAME MARY McCORA	14. NAME OF HUSBAND OR WIFE None
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) none		16. SOCIAL SECURITY NO. none	17. INFORMANT Name E. Hadrick Address Robertson MO.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension and nephritis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Infirmities of age DUE TO (c) 593 X			INTERVAL BETWEEN ONSET AND DEATH 2 weeks
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 Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from September 9 - 1958 and last saw her alive on 5-18-60 Death occurred at 5:30 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE J. D. [Signature] (Degree or title)		22b. ADDRESS 5915 Jefferson, Kirkwood	22c. DATE SIGNED 5-19-60
23a. NAME OF CEMETERY OR CREMATORY Washington Park		23d. LOCATION (City, town, or county) (State) St. Louis CO, MO	
24. FUNERAL DIRECTOR SWAN-MCBHEE UNION		25. DATE RECD. BY LOCAL REG. 5-21-60	26. REGISTRAR'S SIGNATURE John G. Murphy M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

securing the medical certification in the specific manner required by 193.140 MoRS 1949.

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.

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 *Edward A Flynn*

Licensed Embalmer No. *4444*

P. O. Address *St Louis*

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.