SSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

TMENT OF PUBLIC HEALTH AND WELFARE

-61-047792

STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12393

FILED JAN 23 1962

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Illinois b. COUNTY St. Clair

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri — Length of stay in 1b 12 Hours

c. CITY OR TOWN East St. Louis — Inside Limits Yes ☒ No ☐

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St. Mary's Infirmary — Inside Limits Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location) 1812 Kansas Avenue — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First LOUVENIA Middle Last FORD

4. DATE OF DEATH Month December Day 29, Year 1961

5. SEX Female

6. COLOR OR RACE Negro

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH 12/25/1888

9. AGE (last birthday) 73 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (City and state or country) Phillips, Mississippi

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

13a. FATHER'S NAME LOUIS LEWIS

13b. MOTHER'S MAIDEN NAME LAURA GLASGOW

14. NAME OF HUSBAND OR WIFE NONE

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. Unknown

17. INFORMANT Address E.St.Louis,Ill. Eugene Lewis, 1715 Cleveland Avenue,

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 Apoplexy. — INTERVAL BETWEEN ONSET AND DEATH

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

DUE TO (c) 334x

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

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

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 _____, to _____ and last saw her/him alive on _____

Death occurred at 11 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Joseph M. Queen Deputy Coroner

22b. ADDRESS 1300 Clark

22c. DATE SIGNED 12-30-61

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE 1/3/62

23c. NAME OF CEMETERY OR CREMATORY Sunset Gardens of Memory

23d. LOCATION (City, town, or county) (State) Stookey Township, Illinois

24. FUNERAL DIRECTOR Marion E. Officer — ADDRESS 2114 Missouri Avenue St. Louis, Illinois

25. DATE RECD. BY LOCAL REG. JAN 2 1962

26. REGISTRAR'S SIGNATURE Ead Smith M.D.

DATE AMENDED — INSTEAD OF — DOCUMENT — SHOULD READ — ITEM NO. — BY AFFIDAVIT OF — 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_____ Signed Frank Prokopf

Signature of Student Embalmer

Licensed Embalmer No. 4356

P. O. Address St Louis, M

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.