

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3371

State File No.

FILED JAN 19 1954

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **7**

1. PLACE OF DEATH a. COUNTY 0		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Oklahoma b. COUNTY Creek	
b. CITY OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Repeo 8350	
d. FULL NAME OF HOSPITAL OR INSTITUTION Frisco Employees Hospital Assn.		d. STREET ADDRESS (If rural, give location) Box 291	
3. NAME OF DECEASED (Type or Print) a. (First) Everett b. (Middle) Osie c. (Last) Underwood		4. DATE OF DEATH (Month) (Day) (Year) Jan 1st 1954	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Aug. 10, 1907
9. AGE (In years last birthday) 46 yr		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) section laborer	10b. KIND OF BUSINESS OR INDUSTRY Nail Road
11. BIRTHPLACE (State or foreign country) Enon Ark - Carroll Co., Ark		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13a. FATHER'S NAME Marion Underwood		13b. MOTHER'S MAIDEN NAME Mary Olevins	
14. NAME OF HUSBAND OR WIFE Laura Hammond - Deceased		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Sister, Mrs Grace Mallow	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Adeno Carcinoma with generalized metastases INTERVAL BETWEEN ONSET AND DEATH 1 yr 2 mo ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 2002		22. I hereby certify that I attended the deceased from Nov. 11th , 1953, to Jan 1st , 1954, that I last saw the deceased alive on Jan 1st , 1954, and that death occurred at 7:10 P.m. , from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) Norman C. Miller M.D.		23b. ADDRESS 4960 Laclade	
23c. DATE SIGNED Jan 1st, 54		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE 1-2-54		24c. NAME OF CEMETERY OR CREMATORY Local	
24d. LOCATION (City, town, or county) (State) Bristow Oklahoma		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe 4700 Washington	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JAN 2 1954		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe 4700 Washington	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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
Student Embalmer

Signed

Fred J. Farmer

Licensed Embalmer No. 4788

P. O. Address St. Louis Mo.

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 this body is not embalmed, fact should be so stated above.