

FILED DEC 16 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 42595

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 10422

1. PLACE OF DEATH a. COUNTY <u>St. Louis Mo</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN _____		c. LENGTH OF STAY (In this place) _____	c. CITY OR TOWN <u>St. Louis</u>		d. In Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION. <u>2615 Spruce St</u>			e. STREET ADDRESS (If rural, give location) <u>22 2615 Spruce St 2229 0</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Ida</u> b. (Middle) <u>Mc Gill</u> c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov 12. 1954</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>26 April 1897</u>	9. AGE (In years last birthday) <u>57</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 52 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) _____		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Carrie Mill Ill</u>		12. CITIZEN OF WHAT COUNTRY? <u>Yes</u>	
13a. FATHER'S NAME <u>Wiley Cofield</u>		13b. MOTHER'S MAIDEN NAME <u>Nannie Gann</u>		14. NAME OF HUSBAND OR WIFE <u>Mr Edward McGill</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>495-32-0543</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mr Edward Mc Gill 2615 Spruce</u>			
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) <u>Carcinoma Colon</u> ANTECEDENT CAUSES <u>Carcinoma of breast</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last... DUE TO (b) <u>Generalized Carcinomatosis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u>	
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of Transverse Colon - spread to lymph nodes</u>				20. AUTOPSY? <input checked="" 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) _____		21f. HOW DID INJURY OCCUR? <u>153X</u>		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22. I hereby certify that I attended the deceased from <u>11/12/54</u> , 19 <u>54</u> , to <u>11/12</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>11/12</u> , 19 <u>54</u> , and that death occurred at <u>11:00</u> m., from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) <u>[Signature]</u>		23b. ADDRESS <u>8250 Jefferson</u>		23c. DATE SIGNED <u>11-16-54</u>		
24a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>11/18/54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Washington Park</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo</u>			
DATE REC'D BY LOCAL REG. <u>NOV 17 1954</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Herman J. Smith 4247/w Labadie</u>			

(Licensed Embalmer's Statement on Reverse Side)

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

STATE OF TEXAS  
DEPARTMENT OF HEALTH  
DIVISION OF PUBLIC HEALTH

THIS IS TO CERTIFY THAT THE BODY OF \_\_\_\_\_  
DECEASED \_\_\_\_\_  
ON \_\_\_\_\_ AT \_\_\_\_\_  
CITY OF \_\_\_\_\_ COUNTY OF \_\_\_\_\_  
STATE OF TEXAS WAS EXAMINED BY ME OR BY \_\_\_\_\_  
A LICENSED EMBALMER AND FOUND TO BE IN SUCH A CONDITION AS TO  
REQUIRE EMBALMING.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was examined  
by me, or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed *W.C. Gentry*  
\_\_\_\_\_

Licensed Embalmer No. *39*  
P. O. Address *4575d*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
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.