

FILED MAY 13 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13391

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3884**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		STREET ADDRESS (If rural, give location) 22 1404 Papin	
3. NAME OF DECEASED (Type or Print) a. (First) Mary		b. (Middle) Hamilton	
c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) 4 27 55	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 11-1-1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Housewife	9. AGE (In years last birthday) 54
11a. FATHER'S NAME Unknown		11b. MOTHER'S MAIDEN NAME Unknown	11c. NAME OF HUSBAND OR WIFE Dead
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 499-281463	
17. INFORMANT'S SIGNATURE OR NAME Wilford Thompson		ADDRESS	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Epidermoid Carcinoma of Pharyngeal Tonsil with Metastasis to Cervical Lymph Nodes ANTECEDENT CAUSES DUE TO (b) Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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) (Minute)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 145X			
22. I hereby certify that I attended the deceased from 12-6 , 19 54 , to 4-27 , 19 55 , that I last saw the deceased alive on 4-27 , 19 55 , and that death occurred at 5:00P m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Frank O. Richards M.D.		23b. ADDRESS 2601 N. Whittier	
23c. DATE SIGNED 4-29-55			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 5-3-55	
24c. NAME OF CEMETERY OR CREMATORY Oakdale		24d. LOCATION (City, town, or county) (State) Lemay Mo	
DATE REC'D BY LOCAL REG. MAY 2 1955		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Carl Smith Mo Thomas Jackson 6726 Dickson	

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.....
Signature of Student Embalmer

Signed *John K. Cunningham*

Licensed Embalmer No..... 447

P. O. Address..... 2405 Marcu

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.