

FILED FEB 17 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7006

State File No.

318

REG. DIST. NO.

1003

Registrar's No.

1314

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.							
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE				b. COUNTY					
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN St. Louis				c. LENGTH OF STAY (in this place)		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>					
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital				STREET ADDRESS 2618 Bellglade		(If rural, give location) 2170							
3. NAME OF DECEASED (Type or Print) a. (First) Elizabeth			b. (Middle)			c. (Last) Oatts			4. DATE OF DEATH (Month) (Day) (Year) 2 2 56				
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 8-29-1922		9. AGE (In years last birthday) 33		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY None				11. BIRTHPLACE (City and State or Foreign Country) Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.			
13a. FATHER'S NAME Sam Collins				13b. MOTHER'S MAIDEN NAME Fannie Collins				14. NAME OF HUSBAND OR WIFE Milton Oatts					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 492-26-5849		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Milton Oatts 2618 Belleglade							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)				MEDICAL CERTIFICATION								INTERVAL BETWEEN ONSET AND DEATH	
				I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Breast - Cancer with Metastases to Brain and Bone								Undt.	
				ANTECEDENT CAUSES									
				*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.									
				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 type="checkbox"/> NO <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)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.				21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from 12-22, 1955, to 2-2, 1956, that I last saw the deceased alive on 2-2, 1956, and that death occurred at 8:40 p.m., from the causes and on the date stated above.													
23a. SIGNATURE Frank O. Richards (Degree or title) M.D.						23b. ADDRESS 2601 N. Whittier			23c. DATE SIGNED 2-3-56				
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal			24b. DATE 2-7-56			24c. NAME OF CEMETERY OR CREMATORY Washington Park			24d. LOCATION (City, town, or county) (State) St. Louis County				
DATE REC'D BY LOCAL REG. FEB 7 1956			REGISTRAR'S SIGNATURE J. Carl Smith			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. McClendon 4535 Washington							

(Licensed Embalmer's Statement on Reverse Side)

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. *442*

P. O. Address *2405 Mar*

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.