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 diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.  
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

39394

STATE FILE NUMBER 10145

FILED NOV 28 1956

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

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, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips			Length of stay in 1b	d. STREET ADDRESS 2801 Delmar (If outside, give location)	
3. NAME OF DECEASED (Type or print) Betty			First	Middle	Last
4. DATE OF DEATH			Month 11	Day 3	Year 56
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1889	9. AGE (In years less birthday) 67	IF UNDER 1 YEAR Month 5 Day 2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Aberdeen, Mississippi	12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Jackman Fields			14. MOTHER'S MAIDEN NAME J Smitha ?		
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. None	17. INFORMANT Address Nelson Classberry 2801 Delmar		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis					INTERVAL BETWEEN ONSET AND DEATH urdet
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					DUE TO (b)
					DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Adenocarcinoma of Breast					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 170x		
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 9-14-56 to 11-3-56 and last saw her alive on 11-3-56 Death occurred at 9:00 A m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Hugh Waters, M.D.			22b. ADDRESS 2601 Whittier Street		22c. DATE SIGNED 11-5-56
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11/9/56	23c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery	23d. LOCATION (City, town, or county) Berkley, Missouri (State)		
24. FUNERAL DIRECTOR Elmer Kornee 1221 N. Grand ADDRESS		25. DATE RECD. BY LOCAL REG. NOV 7 1956		26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. m. J. B.	

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STATEMENT BY LICENSED EMBALMER

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

Student.....  
Signature of Student Embalmer

Signed *Clarence Adams*

Licensed Embalmer No. *47*

P. O. Address *122/210*

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.