Health,
& Welfare
Public
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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

FILED MAR 18 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 10155

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1192

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Homer G. Phillips — Length of stay in Hospital or Institution: 27 days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY
c. CITY OR TOWN: St Louis — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 113 S. Beaumont — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Queen Middle: Esther Last: Dent
4. DATE OF DEATH: Month 2 Day 2 Year 57
5. SEX: Female 3
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ 3 DIVORCED ☑
8. DATE OF BIRTH: 4-2-1911
9. AGE (In years last birthday): 45
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CAR CLEANER
10b. KIND OF BUSINESS OR INDUSTRY: PULLMAN CO.
11. BIRTHPLACE (City and state or country): UNIONSPRINGS ALA.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: JAMES Scott
14. MOTHER'S MAIDEN NAME: ANNIE P. DAVENPORT
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 494-24-2284
17. INFORMANT: Mrs Rosie Lee Jackson Address: 1743 COLE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Breast - Metastatic — INTERVAL BETWEEN ONSET AND DEATH: undet.
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): 170 K
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 11-15-56 to 2-2-57 and last saw her alive on 2-2-57
Death occurred at 6:15 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Frank O. Richards, M.D
22b. ADDRESS: 2601 Whittier Street
22c. DATE SIGNED: 2-4-57

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
23b. DATE: 2-9-57
23c. NAME OF CEMETERY OR CREMATORY: WASHINGTON PARK
23d. LOCATION (City, town, or county) (State): St Louis Co. Mo.

24. FUNERAL DIRECTOR: Bennie Love ADDRESS: 3103 Washington
25. DATE RECD. BY LOCAL REG.: FEB 5 '57
26. REGISTRAR'S SIGNATURE: Earl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed W. Claude Gordon

Licensed Embalmer No 348

P. O. Address 4575 Al

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