

FILED APR 12 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10524

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **2452**

| | | | |
|---|--|---|--|
| 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 checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN St. Louis |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Luke's Hospital | | Length of stay in lb 2 | d. STREET ADDRESS 1701a S. 9th |
| 3. NAME OF DECEASED (Type or print) RUBY | | First RUBY | Middle KELLEY |
| 4. DATE OF DEATH Month 3 Day 11 Year 57 | | 5. SEX Female | |
| 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH 5-8-1915 | | 9. AGE (In years last birthday) 41 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (City and state or country) Corinth, Mississippi | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Nola Fite | | 14. MOTHER'S MAIDEN NAME Ollie James | |
| 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. — | |
| 17. INFORMANT William Kelley, 1701a S. 9th | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE-(a) Generalized Carcinomatosis DUE TO (b) Serous cystadenocarcinoma of the ovary DUE TO (c) the ovary Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH 16 months |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2 |
| 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.) 175x | |
| 20c. TIME OF INJURY Hour a. m. p. m. | | 20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) | |
| 20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | |
| 21. I attended the deceased from Nov 1956 to March 11, 1957 and last saw her alive on 3/10/57 Death occurred at 8:55 A m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE R. G. Holland M.D. | | 22b. ADDRESS 5535 Delmar | |
| 22c. DATE SIGNED 3/11/57 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 3-12-1957 | |
| 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town, or county) (State) Corinth, Mississippi | |
| 24. FUNERAL DIRECTOR McLAUGHLIN'S, 2301 Lafayette | | 25. DATE RECD. BY LOCAL REG. MAR 12 '57 | |
| 26. REGISTRAR'S SIGNATURE Carl Smith Mo ms | | | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

300
1-56Health, Welfare, Public Service
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.
Securing the medical certificate in the specific manner required by 130.140-Mo-1-1947.

8001

RETURN

YOUR

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 *James R. Chapman*

Licensed Embalmer No. *45*

P. O. Address *St. Louis, Mo.*

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.