

FILED MAY - 8 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14834

STATE FILE NUMBER
3890

318

1003

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		a. STATE ILLINOIS b. COUNTY ST. CLAIR	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION PEOPLES		c. CITY OR TOWN CENTREVILLE TOWNSHIP	
Length of stay in 1b		d. STREET ADDRESS 5619 Gay Avenue	
19		(If outside, give location) Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last BERNIECE HUGHES			4. DATE OF DEATH Month Day Year April 16, 1957		
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 26, 1929	9. AGE (In years last birthday) 27	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Aubrey, Arkansas	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ALEX AUSTIN			14. MOTHER'S MAIDEN NAME LEAH (UNKNOWN)		

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. Unknown	17. INFORMANT Joe Hughes, 5619 Gay, East St. Louis, Ill.
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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 THE COLON WITH METASTASES		INTERVAL BETWEEN ONSET AND DEATH 1 yr
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)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)	
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 2/15/57 to 4/16/57 and last saw her alive on 4/14/57 Death occurred at 9:30 p. m. on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) Chas. R. Frazier, M.D.	22b. ADDRESS 1419 Kansas	22c. DATE SIGNED 4/17/57

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 4/18/57	23c. NAME OF CEMETERY OR CREMATORY Booker Washington	23d. LOCATION (City, town, or county) (State) Centreville Twnship, Ill.
24. FUNERAL DIRECTOR Marion E. Officer, 2114 Mo. Ave. E. St. Louis, Ill.		25. DATE RECD. BY LOCAL REG. APR 23 '57	26. REGISTRAR'S SIGNATURE J. Carl Smith

(Licensed Embalmer's Statement on Reverse Side)

1. Health & Welfare
2. Public Health ServiceS. 300
v. 1-56

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

securing the medical certification in the specific manner required by 193.140 MO RS 1949.

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 *Bess H. Baldwin*.....

Licensed Embalmer No. *242*

P. O. Address *721 N. 26th*

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.