

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25946

FILED JUL 26 1957

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STATE FILE NUMBER 8536

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) a. STATE Illinois b. COUNTY Johnson			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Belknap	
e. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL				Length of stay in lb		d. STREET ADDRESS (If outside, give location) 322	
3. NAME OF DECEASED (Type or print) First PAULINE Middle RUBY Last BETTS				4. DATE OF DEATH Month JULY Day 12 Year 1957			
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 Sept 1926	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and state or country) Unionville, Illinois.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hyder Harris				14. MOTHER'S MAIDEN NAME Mary Cochran			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No Nil				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Lindell Betts, Belknap, Illinois.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LEUKOSARCOMA						INTERVAL BETWEEN ONSET AND DEATH 2 MOS.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____						200.2	
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 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 _____ 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 JUNE 3, 1957 to JULY 12, 1957 and last saw her alive on JULY 12, 1957 Death occurred at 2:30 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Name or title) Harold J. Joseph M.D.				22b. ADDRESS BARNES HOSPITAL		22c. DATE SIGNED 7/13/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. NAME OF CEMETERY OR CREMATORY Masonic Cemetary		23d. LOCATION (City, town, or county) Belknap, Illinois.		(State)	
24. FUNERAL DIRECTOR Albert H. Hoppe, 4700 Washington Blvd.		ADDRESS		25. DATE RECD. BY LOCAL REG. JUL 13 57		26. REGISTRAR'S SIGNATURE J. Carl Smith M.D.	

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

MEDICAL CERTIFICATION

