

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26523

FILED JUL 26 1957

318

1003

STATE FILE NUMBER
6700

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

300
1-56

1. PLACE OF DEATH a. COUNTY Mo		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo 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 Mo. Baptist Hosp Length of stay in 1b		STREET ADDRESS 4950 1/2 Fyler Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle B Last Saad		4. DATE OF DEATH Month July Day 17 Year 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 15, 1903
9. AGE (In years last birthday) 53		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	11. BIRTHPLACE (City and state or country) Winona, Mo
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thomas Allmon		14. MOTHER'S MAIDEN NAME Martha Sisco	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give year or dates of service) NO		16. SOCIAL SECURITY NO. 483-16-8674	17. INFORMANT Christine Roberts Address 4950 1/2 Fyler
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liver and Adrenal Insufficiency Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Metastatic Carcinoma DUE TO (c) Carcinoma Rt Breast			INTERVAL BETWEEN ONSET AND DEATH 3 Wks 2 mo 3 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None Remarkable			19. WAS AUTOPSY PERFORMED? YES <input checked="" 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 · 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 Dec 15-4 to July 17 1957 and last saw her alive on July 17, 1957 . Death occurred at 11:50 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Joseph E. Green M.D.		22b. ADDRESS 607 N. Grand Blvd	22c. DATE SIGNED 7/18/57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7-20-57	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State) Springfield, Missouri
24. FUNERAL DIRECTOR Kriegshauser ADDRESS 4228 So. Kingshighway		25. DATE RECD. BY LOCAL REG. JUL 18 57	26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item B. 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

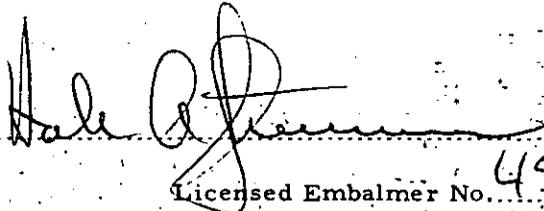
3. P

Thurs 3 to 5 Pm
1115 and Librarian's Shop.

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 
Licensed Embalmer No. 45

P. O. Address

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.