

Diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

FILED AUG 26 1957

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

29189

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **7307**

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3811a Ashland Av</b>		Length of stay in 1b	d. STREET ADDRESS <b>3811a Ashland</b>		Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Flora Banks</b>			4. DATE OF DEATH Month <b>Aug.</b> Day <b>3</b> Year <b>1957</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 2, 1874</b>	9. AGE (In years last birthday) <b>82</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Savannah, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>Isaac Hill</b>			14. MOTHER'S MAIDEN NAME <b>Lizy Gales</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Catherine Johnson, 3811a Ashland Ave.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of Pancreas with Metastasis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>4 months</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					<b>157X</b>
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"/> <b>2</b>
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 <b>March 1, 57</b> to <b>Aug 3 57</b> and last saw her alive on <b>Aug. 3, 57</b> Death occurred at <b>6 a. m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <b>Walter G. Young, M.D.</b>			22b. ADDRESS <b>2337 Market St. St. Louis, Mo.</b>		22c. DATE SIGNED <b>Aug 3, 57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>8-3-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Local</b>	23d. LOCATION (City, town, or county) <b>Slater, Mo.</b>		(State)
24. FUNERAL DIRECTOR ADDRESS <b>Albert H. Hoppe 4700 Washington Blvd.</b>			25. DATE RECD. BY LOCAL REG. <b>AUG 5 57</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

AUG 28 1957

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.....  
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.