

Health,
& Welfare
Public
Service

S. 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

FILED NOV 19 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42325

STATE FILE NUMBER

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

10762

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 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 Homer G. Phillips		Length of stay in 1b	STREET ADDRESS 2516 N. Vandeventer (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Letitia Middle Mechele Last Martin			4. DATE OF DEATH Month 11 Day 7 Year 57		
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-18-57	9. AGE (In years last birthday) IF UNDER 1 YEAR Months 20 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (City and state or country) Saint Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Robert Fraizer			14. MOTHER'S, MAIDEN NAME May Rose Martin		
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. None	17. INFORMANT Address Mrs. Mary D. Jett, R.R.L. 2601 Whittier		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Partial Intestinal Obstruction with Gangrene of Mid Transverse Colon and Jejunum					INTERVAL BETWEEN ONSET AND DEATH undet.
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) Inflammation of Peritoneum - Sub acute Edema of Brain					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.) 5705.			
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 10-18-57 to 11-7-57 and last saw her her alive on 11-7-57 Death occurred at 8:10 A m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Parke N. Wood, M.D.			22b. ADDRESS 2601 Whittier Street		22c. DATE SIGNED 11-8-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 11/12/57	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis, Missouri
24. FUNERAL DIRECTOR C.W. Roberts Und. Co 1416 N. Taylor Ave.		25. DATE RECD. BY LOCAL REG. NOV 12 57		26. REGISTRAR'S SIGNATURE J. Park Smith, m.d.	

(Licensed Embalmer's Statement on Reverse Side)

MISSOURI

St. Louis

State of Missouri

Board of Embalmers

7 11

10-12-27

Female

27

10-12-27

10-12-27

10-12-27

10-12-27

10-12-27

10-12-27

10-12-27

STATEMENT BY LICENSED EMBALMER

10-12-27

10-12-27

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

by me, or by No Embalming, Student Embalmer No.

working under my personal supervision.

Student
Signature of Student Embalmer

Signed Annie Robert

Licensed Embalmer No. 44

P. O. Address Haus

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.