

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 13 1958

45951
STATE FILE NUMBER
12584

Registration District No. 318 Primary Registration District No. 1003

Registrar's No.

S. 300
v. 1-57

1. PLACE OF DEATH a. COUNTY <u>St. Louis City</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <u>St. Louis City</u> TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis City</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Missouri Pacific Hospital</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>450 5033 Louisiana</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>LeRoy</u> Last <u>Irwin</u>			4. DATE OF DEATH Month <u>December</u> Day <u>29</u> Year <u>1957</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept-20-1897</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brine Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grey Packing</u>	9. AGE (In years last birthday) <u>60</u> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
11. BIRTHPLACE (City and state or country) <u>DeSoto, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Unknown Irwin</u>		13b. MOTHER'S MAIDEN NAME <u>Florence Unknown</u>	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	17. INFORMANT Address <u>Mrs. Paul Raines, 5033 Louisiana Ave.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GENERALIZED CARCINOMA TOLUS</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>ANAPLASTIC CARCINOMA OF NASO-pharynx</u> DUE TO (c) <u>BRONCHIAL PNEUMONIA</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 MONTHS</u> <u>18 MONTHS</u> <u>3 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>146x</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
20a. ACCIDENT: SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 <u>Dec 26, 1957</u> to <u>Dec 29, 1957</u> and last saw ^{him} alive on <u>12/28/57</u> Death occurred at <u>10: A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>John A. Carrer, MD</u> (Degree or title)		22b. ADDRESS <u>462 N. Taylor</u>	22c. DATE SIGNED <u>12-29-57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <u>12-31-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New St. Marcus Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo</u>
24. FUNERAL DIRECTOR ADDRESS <u>Calvin F. Feutz 4828 Natural Bridge</u>		25. DATE RECD. BY LOCAL REG. <u>DEC 30 57</u>	26. REGISTRAR'S SIGNATURE <u>J. Paul Smith, M.D.</u> <u>M.D. B.</u>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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.

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 *John A. Melinas*

Licensed Embalmer No. *4186*

P. O. Address *St. Louis*

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.