

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 17 1958

318

1003

STATE FILE NUMBER 2845-189

Registration District No. Primary Registration District No. 1003 Registrar's No.

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis 12, Mo.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis 12,</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTE <u>Masonic Home of Mo.</u>		Length of stay in 1b <u>40 yrs.</u>	d. STREET ADDRESS <u>5351 Delmar Blvd.</u> (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Christine</u> Middle <u>Johanna</u> Last <u>Duis</u>			4. DATE OF DEATH Month <u>1</u> Day <u>7</u> Year <u>58</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-23-1881</u>	9. AGE (In years last birthday) <u>76</u> IF UNDER 1 YEAR Month <u>1</u> Day <u>15</u> IF UNDER 24 HRS. Hours <u>35</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Dorsey, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Frank Duis</u>			14. MOTHER'S MAIDEN NAME <u>Malissa Zimmermann</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Louis C. Robertson, Agent</u> Address		
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>Carcinoma of Stomach</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					<u>151X</u>
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"/> <u>2</u>
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 <u>1-28-57</u> to <u>1-6-58</u> and last saw ^{her} _{him} alive on <u>1-6-58</u> Death occurred at <u>10:45</u> a.m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Harold E. Walters M.D.</u> (Degree or title)			22b. ADDRESS <u>3720 Washington St. Louis Mo.</u>		22c. DATE SIGNED <u>1-7-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal Auto Jan 9, 1958</u>		23b. DATE <u>Duis Cemetery</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dorsey, Illinois</u>	
23d. LOCATION (City, town, or county) (State) <u>Dorsey, Illinois</u>					
24. FUNERAL DIRECTOR <u>Alexander & Sons, Inc 6175 Delmar</u>		25. DATE RECD. BY LOCAL REG. <u>JAN 8 '58</u>		26. REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u> <u>m 80</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *J. S. E. McCulloch*.....
Licensed Embalmer No. *276*

P. O. Address *6150 R*

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.