

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-007547
STATE FILE NUMBER

FILED MAR 10 1958

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **1434**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis 12, Mo.		c. CITY OR TOWN Webster Groves, Mo	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hosp.		d. STREET ADDRESS (If outside, give location) 634 Mildred Ave.	
3. NAME OF DECEASED (Type or print) MISS CARRIE (NMN) MARKHAM		4. DATE OF DEATH Feb. 5, 1958	
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 23, 1871
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher (ret.)		10b. KIND OF BUSINESS OR INDUSTRY St. Louis Public Schools	11. BIRTHPLACE (City and state or country) New York, N. Y.
13. FATHER'S NAME George S. Markham		14. MOTHER'S MAIDEN NAME Carolina Williams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT Address Garard E. Markham 634 Mildred
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, metastatic to skull and spine			INTERVAL BETWEEN ONSET AND DEATH 8 weeks
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) 1969			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2
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. 30, '57 to Feb. 5, '58 and last saw her alive on Feb. 5, '58 Death occurred at 2:30 P. M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Arthur B. Day M.D.		22b. ADDRESS 3720 Washington	22c. DATE SIGNED 2.7.58
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Feb. 8, 1958	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis Co, Missouri
24. FUNERAL DIRECTOR ADDRESS Alexander & Sons, Inc. 6175 Delmar		25. DATE RECD. BY LOCAL REG. FEB 7 '58	26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D.

M.S.B.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Dr. Anthony Day
3720 Washington

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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..... *Joseph McCullough*

Licensed Embalmer No. *248*

P. O. Address *6175th*

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.