

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-007870
STATE FILE NUMBER

FILED FEB 28 1958

318

1003

1365

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

health, Welfare public service
300 1-56
All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. 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

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Jewish Hospital</u>			Length of stay in lb <u>68yrs</u>	STREET ADDRESS (If outside, give location) <u>269 5879 Wabada</u>	
3. NAME OF DECEASED (Type or print) First <u>Annie</u> Middle <u>NMN</u> Last <u>Stobie</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>3,</u> Year <u>1958</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 16, 1890</u>	9. AGE (In years last birthday) <u>67yrs</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Riley</u>			14. MOTHER'S MAIDEN NAME <u>Sarah Lee</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mr. James H. Stobie Rt#2 Box279</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>Carcinoma of Colon</u> DUE TO (b) <u>metastases to liver</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u> <u>6 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>153.8</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)		
20c. TIME OF INJURY Hour <u> </u> Month, Day, Year a. m. <u> </u> p. m. <u> </u>					
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>Oct. 1955</u> to <u>Feb. 3, 1958</u> and last saw her <u>alive</u> on <u>Feb. 3, 1958</u> Death occurred at <u>5:15</u> <u>p</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Llewellyn Sale, M.D.</u>			22b. ADDRESS <u>100 N. Euclid</u>		22c. DATE SIGNED <u>2/4/58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Feb. 6, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>	
24. FUNERAL DIRECTOR <u>Alexander & Sons</u>		ADDRESS <u>6175 Delmar</u>	25. DATE RECD. BY LOCAL REG. <u>FEB 5 '58</u>	26. REGISTRAR'S SIGNATURE <u>J. Carl Smith MD</u>	

(Licensed Embalmer's Statement on Reverse Side)

7m8B

Dr. L. Lewellyn Sale Jr
100 N Euclid

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 *Jos. E. McCulloch*.....

Licensed Embalmer No. *2960*

P. O. Address *612 S. 2nd St.*

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.