

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-011854

STATE FILE NUMBER

1003

Registrar's No. 3574

FILED APR 3 1958

Registration District No.

318

Primary Registration District No.

300
-57

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
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		Length of stay in lb 129	d. STREET ADDRESS (If outside, give location) 5223 Enright

3. NAME OF DECEASED (Type or print) First Middle Last Lela Kennedy			4. DATE OF DEATH Month Day Year 3 27 58	
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5. SEX Female 3	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2- -1891	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NIL	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) HENDERSON, TENN. 1	12. CITIZEN OF WHAT COUNTRY? USA.
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13a. FATHER'S NAME JAKE BARHAM	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE CICERO
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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. 499-25-2917	17. INFORMANT MRS. PEARL REED, 1 HARE ST. MADISON, ILL.	Address EAGLE PARK
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Epidermoid carcinoma of cervix with extension and metastasis DUE TO (b) DUE TO (c) Pyelonephritis with hydronephrosis		INTERVAL BETWEEN ONSET AND DEATH Undet.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 171X		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.)
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
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21. I attended the deceased from 1-27-58 to 3-27-58 and last saw her alive on 3-27-58
Death occurred at 6:55 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) E. Y. Straven, M.D., M.D.	22b. ADDRESS 2601 N. Whittier St.	22c. DATE SIGNED 3-28-58
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23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 4-3-58	23c. NAME OF CEMETERY OR CREMATORY WASHINGTON PARK	23d. LOCATION (City, town, or county) (State) St. Louis Co. MO.
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24. FUNERAL DIRECTOR Price Benevolent Order of Friends 2829 Washington Blvd.	25. DATE RECD. BY LOCAL REG. MAR 29 '58	26. REGISTRAR'S SIGNATURE Pearl Reed MRS.
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 *W. CLAUDE GORDON*

Licensed Embalmer No. *3489*

P. O. Address *4575 Alder*

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.