

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-011870

STATE FILE NUMBER

FILED APR 9 1958

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **3659**

Health, Welfare, Public Service  
300  
1-56  
All diseases in Part I must be causally 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. I must be causally related. Coroner cannot certify to a death due to natural causes.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY						
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>St. Louis</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3902a N. 23rd. St</b>				Length of stay in lb		d. STREET ADDRESS (If outside, give location) <b>3902a N. 23rd. St</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Ivery Kittrell</b>				First		Middle		Last		
4. DATE OF DEATH <b>3-30-1958</b>		Month		Day		Year				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-1-1905</b>		9. AGE (In years last birthday) <b>53</b>		IF UNDER 1 YEAR Months <b>1</b> Days <b>29</b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Homemaker</b>		11. BIRTHPLACE (City and state or country) <b>Clay County, Arkansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Robert Black</b>				14. MOTHER'S MAIDEN NAME <b>Nancy Brent</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>500-18-0267</b>		17. INFORMANT <b>George Kittrell</b>				Address <b>3902a N. 23rd St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer</b> <b>Carcinoma of right ovary</b> DUE TO (b) <b>RIGHT Ovary</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>175.0</b>								INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>		
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 <b></b> Month <b></b> Day <b></b> Year <b></b> a. m. <b></b> p. m. <b></b>										
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 <b>Jan 10, 1958</b> to <b>March 30 1958</b> and last saw her alive on <b>March 30</b> Death occurred at <b>11 P.M.</b> <b>11</b> p.m. on the date stated above; and to the best of my knowledge, from the causes stated.										
22a. SIGNATURE (Degree or title) <b>Chas. M. Mellies D.O.</b> <i>Charles M. Mellies</i>				22b. ADDRESS <b>3823 No. 20th N. 20th</b>			22c. DATE SIGNED <b>3/31/58</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal-Rail 3-31-1958</b>		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town, or county) (State) <b>Corning, Arkansas</b>				
24. FUNERAL DIRECTOR <b>Russel-Ermert Corning, Arkansas</b>				25. DATE RECD. BY LOCAL REG. <b>MAR 31 '58</b>		26. REGISTRAR'S SIGNATURE <i>J. Carl Smith MD</i> <b>mjb</b>				

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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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.....  
*Harvey Kable*

Licensed Embalmer No. *45*

P. O. Address *Florida*

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.