

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12434
58-~~62224~~
STATE FILE NUMBER

FILED MAR 27 1958

318

1003

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **3329**

Health, Welfare, Public Service
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Deaths in Part I must be casually related. Coroner cannot certify to a death due to natural causes.
Deaths, burials, etc. may only be certified when there is no other cause of death stated.
Deaths in Part I must be casually 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 Missouri b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		Length of stay in Ib		d. STREET ADDRESS (If outside, give location) 4243a E. Easton		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Carrie Middle D. Last Vaden				4. DATE OF DEATH Month 3 Day 20 Year 58				
5. SEX Female 3		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 12, 1891		
9. AGE (In years last birthday) 66		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil			10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and state or country) Gadsden, Alabama /		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Kemp Shook				14. MOTHER'S MAIDEN NAME Rodie Clark				
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. None		17. INFORMANT George W. Shook Address 2420 N. Whittier Street				
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 of Pancreas with extension into Duodenum							INTERVAL BETWEEN ONSET AND DEATH Undet.	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) _____		DUE TO (c) _____			157x	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized Arteriosclerosis and Diabetes Mellitus							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 _____ a. m. _____ p. m. _____ Month, Day, Year _____								
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 1-31-58 to 3-20-58 and last saw ^{her} alive on 3-20-58 Death occurred at 8:40 a. m. on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) D. Roberts M.D.				22b. ADDRESS 2601 N. Whittier St.		22c. DATE SIGNED 3-21-58		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 3/26/58	23c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri			
24. FUNERAL DIRECTOR C.W. Roberts Und. Co ADDRESS 1416 N. Taylor Ave			25. DATE RECD. BY LOCAL REG. MAR 22 '58		26. REGISTRAR'S SIGNATURE J. Earl Smith M.D.			

(Licensed Embalmer's Statement on Reverse Side)

Name of Deceased _____
 Date of Death _____
 Place of Death _____
 Name of Embalmer _____
 License No. _____
 Date of License _____
 Address _____
 City _____
 State _____
 Zip _____

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 *James A. Carter*

Licensed Embalmer No. *5*
 P. O. Address *St. Louis*

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.