

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-016735
STATE FILE NUMBER

FILED APR 21 1958

Registration District No. 317 Primary Registration District No. 542 Registrar's No. 953

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY OR TOWN Ferguson		c. CITY OR TOWN Ferguson	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 236 Georgia		d. STREET ADDRESS 236 Georgia Av.	

3. NAME OF DECEASED (Type or print) First Middle Last JULIA WILMA VANCE			4. DATE OF DEATH Month Day Year 4-4-58		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/22/94	9. AGE (In years last birthday) 63	10. F UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during life, even if retired) At Home	10b. KIND OF BUSINESS OR INDUSTRY House Wife	11. BIRTHPLACE (City and state or country) East St. Louis, Ill.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Elmer F. Vance
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) (If No, give year or dates of service) No	16. SOCIAL SECURITY NO. NONE	17. INFORMANT Address Elmer F. Vance 236 Georgia
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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) Carcinoma of colon with generalized metastasis		INTERVAL BETWEEN ONSET AND DEATH 2-3 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ 153.8		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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.)
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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 Death occurred at 3/11/58 4:00 A.M. to 4/4/58 and last saw her alive on 3/11/58 m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Jack T. Steele M.D.	22b. ADDRESS 40 North Florissant Rd.	22c. DATE SIGNED 4-4-58
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 4/7/58	23c. NAME OF CEMETERY OR CREMATORY New Bethlehem Cem.	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
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24. FUNERAL DIRECTOR White-Mullen Mort. 118 N. Florissant Rd.	25. DATE RECD. BY LOCAL REG. 4-5-58	26. REGISTRAR'S SIGNATURE Herbert R. Donke M.D.
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

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 Eleana Province

Licensed Embalmer No. 3403

P. O. Address Jennings

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.