

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-030260

STATE FILE NUMBER 8488

FILED SEP 11 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

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, Missouri.		c. CITY OR TOWN St. Louis	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 3837 Wyoming Street.,		d. STREET ADDRESS (If outside, give location) 3837 Wyoming Street.,	
Length of stay in lb 2 years		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Edna Middle Lorraine Last Christian			4. DATE OF DEATH Month September Day 1 Year 1958			
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 December 29, 1910	9. AGE (In years last birthday) 47	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Kwainee, Missouri.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		

13a. FATHER'S NAME James D. Warren		13b. MOTHER'S MAIDEN NAME Ada Gibson		14. NAME OF HUSBAND OR WIFE Noah Christian	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give name or dates of service) No Nil		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Noah Christian, 3837 Wyoming 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) pulmonary metastases Pulmonary Metastases carcinoma of cervix uteri Carcinoma of Cervix Uteri			INTERVAL BETWEEN ONSET AND DEATH 2 years
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			
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 type="checkbox"/> NO <input checked="" type="checkbox"/> 2

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 <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 Jan 1957 to present and last saw her alive on 8-26-58 Death occurred at 12:00 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE H. R. Butcher (Degree or title) H.R. Butcher MD			22b. ADDRESS 4960 Audubon 4960 Audubon, St. Louis		22c. DATE SIGNED 9/2/58

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 9-2-58	23c. NAME OF CEMETERY OR CREMATORY South Pleasant Valley Cemetery		23d. LOCATION (City, town, or county) (State) Dexter, Missouri.
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24. FUNERAL DIRECTOR Albert H. Hoppe, 4700 Washington Blvd.,		25. DATE RECD. BY LOCAL REG. SEP 2 58	26. REGISTRAR'S SIGNATURE J. Earl Smith, MD S.P.	
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

300
1-57

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 *Lawrence O. Herlihy*

Licensed Embalmer No. *4979*

P. O. Address : *St. Louis, Mo.*

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.