Health, Welfare Public Service

300 -57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-041929
STATE FILE NUMBER

FILED NOV 24 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 10667

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St.Louis — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: DePaul Hospital — Length of stay in 1b: 2 weeks

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: St.Louis
c. CITY OR TOWN: Jennings 4138 — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 8711 Jennings Rd. — Reside on Farm: Yes [ ] No [X]

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3. NAME OF DECEASED (Type or print): First: Ruth Middle: L. Last: Main

4. DATE OF DEATH: Month November Day 5 Year 1958

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] / DIVORCED [ ]
8. DATE OF BIRTH: Dec. 19, 1907
9. AGE (In years last birthday): 50 — 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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): St.Louis, Mo. 0
12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME: Charles E. Beuer
13b. MOTHER'S MAIDEN NAME: Amy Brenton
14. NAME OF HUSBAND OR WIFE: Hiram H. Main

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 488-28-3920
17. INFORMANT: Hiram H. Main, Address: 8711 Jennings Rd.

MEDICAL CERTIFICATION

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 Cervix Uteri with metastases to lungs — INTERVAL BETWEEN ONSET AND DEATH: 1 year
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b)
DUE TO (c) 171X
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 [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]
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 [ ] NOT WHILE AT WORK [ ]
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 10/17/58 to 11/5/58 and last saw her/him alive on 11/5/58
Death occurred at 10:00 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Robert Potashnick M.D. (Degree or title)
22b. ADDRESS: 3720 Washington
22c. DATE SIGNED: 11/6/58

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 11-8-58
23c. NAME OF CEMETERY OR CREMATORY: Valhalla Cemetery
23d. LOCATION (City, town, or county) (State): St.Louis Co., Mo.

24. FUNERAL DIRECTOR: Albert H. Hoppe, ADDRESS: 4700 Washington Blvd.
25. DATE RECD. BY LOCAL REG.: NOV 6 '58
26. REGISTRAR'S SIGNATURE: Earl Smith MD
MDB

(Licensed Embalmer's Statement on Reverse Side)

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 G. W. Wilkinson

Licensed Embalmer No. 35 7

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.