Health, Welfare Public Service

300
-57
3
12

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003021
STATE FILE NUMBER

JAN 26 1959 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 250

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: ST LOUIS (CITY) — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION: FRISCO EMPLOYEES' HOSPITAL — Length of stay in Hospital: 39 DAYS

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY:
c. CITY OR TOWN: ST LOUIS (CITY) — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 4475 a EVANS ST. — Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First: AUGUSTA Middle: Last: HARPER

4. DATE OF DEATH: Month: JAN Day: 6TH Year: 1959

5. SEX: MALE

6. COLOR OR RACE: NEGRO

7. MARRIED [X] **NEVER MARRIED** [ ] **WIDOWED** [ ] **DIVORCED** [ ]

8. DATE OF BIRTH: DEC 24 1892

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): WAITER

10b. KIND OF BUSINESS OR INDUSTRY: RAILROAD

11. BIRTHPLACE (City and state or country): MISSISSIPPI

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: THOMAS

13b. MOTHER'S MAIDEN NAME: BENFORD

14. NAME OF HUSBAND OR WIFE: LILLIAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): W.W I

16. SOCIAL SECURITY NO.: 702-07-9931

17. INFORMANT Address: LILLIAN HARPER (WIFE)

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 SQUAMOUS CELL OF TONGUE WITH METASTASES
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 141.9
INTERVAL BETWEEN ONSET AND DEATH: 39 DAYS
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 [X] NO [ ]

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 11-25-58, to 1-6-59 and last saw ~~her~~ him alive on 1-6-59
Death occurred at 8:45 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): MD
22b. ADDRESS: FRISCO EMPLOYEES' HOSPITAL ST LOUIS MO
22c. DATE SIGNED: 1-6-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 1/12/59
23c. NAME OF CEMETERY OR CREMATORY: National Cemetery
23d. LOCATION (City, town, or county) (State): Jefferson Barracks, Mo

24. FUNERAL DIRECTOR ADDRESS: C.W.Roberts Und.Co 1416 N.Taylor Ave
25. DATE RECD. BY LOCAL REG.: JAN 9 '59
26. REGISTRAR'S SIGNATURE: Paul Smith MD

(Licensed Embalmer's Statement on Reverse Side)

MEDICAL CERTIFICATION

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 James Alzo Co

Licensed Embalmer No. 4681

P. O. Address [illegible] 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.