

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003097
STATE FILE NUMBER

FILED FEB 3 1959

Registration District No. _____ Primary Registration District No. _____ Registrar No. **2-627**

300
1-57
63
72
0

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Wayne | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | c. CITY OR TOWN Fairfield Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL Length of stay in lb | | d. STREET ADDRESS (If outside, give location) 205 Sibley Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First LIMA Middle BELLE Last HUMPHREY | | | 4. DATE OF DEATH Month JANUARY Day 18 Year 1959 |
| 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 Oct. 19, 1899 |
| 9. AGE (In years last birthday) 59 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 11. BIRTHPLACE (City and state or country) Wayne Co., Ill. |
| 12. CITIZEN OF WHAT COUNTRY? U.S. | | 13. FATHER'S NAME Asa Attebery | |
| 13b. MOTHER'S MAIDEN NAME Rhene Hoffee | | 14. NAME OF HUSBAND OR WIFE William P. Humphrey | |
| 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. Unknown | |
| 17. INFORMANT William P. Humphrey, Fairfield, Ill. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRAIN TUMOR, GLIO-BLASTOMA (MALIGNANT) PROBABLE METASTASIS DUE TO (b) CARCINOMA OF BREAST, LEFT DUE TO (c) 170x Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH 2 YEARS |
| 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 JAN. 16, 1959 to JAN. 18, 1959 and last saw her alive on JAN. 18, 1959 Death occurred at 4:45 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE F.R. Bradley (Degree or title) M. D. | | 22b. ADDRESS BARNES HOSPITAL | |
| 22c. DATE SIGNED 1/18/59 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 1-18-59 | |
| 23c. NAME OF CEMETERY OR CREMATORY Local | | 23d. LOCATION (City, town, or county) (State) Fairfield, Ill. | |
| 24. FUNERAL DIRECTOR Albert H. Hoppe, 4700 Washington Blvd. | | 25. DATE RECD. BY LOCAL REG. JAN 19 '59 | |
| 26. REGISTRAR'S SIGNATURE Keen Smith MD | | | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

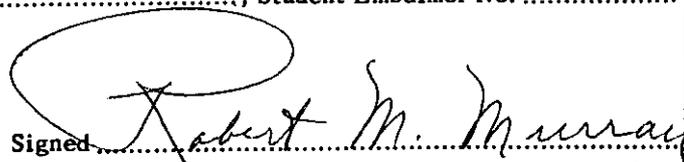
MEDICAL CERTIFICATION

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 

Licensed Embalmer No. 3749

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.