

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003102
STATE FILE NUMBER
127

JAN 26 1959

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

300
1-57
19
104
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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		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Baptist		Length of stay in 1b 42 Yrs	d. STREET ADDRESS (If outside, give location) 3540 North Grand Ave
3. NAME OF DECEASED (Type or print) First MAY Middle C. Last HUTMACHER		4. DATE OF DEATH Month JANUARY Day 5, Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-23-1896
9. AGE (In years last birthday) 62		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Worker	11. BIRTHPLACE (City and state or country) Lanes Prairie, Mo.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Worker		10b. KIND OF BUSINESS OR INDUSTRY Retired	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME West		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Louis N.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 497-091 057	17. INFORMANT Address Louis H. Hutmacher, Imperial, Mo.
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 Cervix DUE TO (b) Carcinoma metastatic pelvic DUE TO (c) abdomen lump. 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 171X
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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 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 11-14-58 to 1/5/59 and last saw her alive on 1-5-59 Death occurred at 2:30 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE George E. Embler		(Degree or title) M.D.	22b. ADDRESS 3720 Leaning Tower
22c. DATE SIGNED 1-6-59			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 1-7-1959	23c. NAME OF CEMETERY OR CREMATORY New Pickers Cemetery	23d. LOCATION (City, town, or country) (State) St. Louis County, Mo.
24. FUNERAL DIRECTOR McLAUGHLIN'S, 2301 Lafayette Ave.		25. DATE RECD. BY LOCAL REG. 1-6-59	26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D. S.P.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be stated. All diseases in Part I must be causally related.

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10/1/11

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 *A. G. Farris*

Licensed Embalmer No. *3384*
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.