

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003246
STATE FILE NUMBER
2 432
Registrar

FILED JAN 28 1959

Registration District No. Primary Registration District No.

300
-57
7
34
9

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input 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 Chronic Hosp.		Length of stay in lb 2 mo.	d. STREET ADDRESS 1018a Marion (If outside, give location) Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last Olinda Mc Roy	4. DATE OF DEATH Month Day Year 1- 13 59
---	--

5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> 3 DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 7, 1909	9. AGE (In years) lay birthday 49	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) at home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	-----------------------------------	---	--

13a. FATHER'S NAME Maritz Hoffman	13b. MOTHER'S MAIDEN NAME Emma Schlattman	14. NAME OF HUSBAND OR WIFE --
--------------------------------------	--	-----------------------------------

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. none	17. INFORMANT Elmer Hoffman	Address St. Louis Co., Mo. 24 Buckley Meadows
---	---------------------------------	--------------------------------	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Metastatic Carcinomatosis</i>		INTERVAL BETWEEN ONSET AND DEATH 3 mo.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <i>Carcinoma of Cervix Uteri 171x</i>		2 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Anemia - secondary to (a) - 3mo.</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

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 <u>10-31-58</u> to <u>1-13-59</u> and last saw her alive on <u>1-13-59</u> Death occurred at <u>1:00 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) <i>John W. Beckham, M.D.</i>	22b. ADDRESS <i>5800 Arsenal</i>	22c. DATE SIGNED <i>1/13/59</i>
--	-------------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 1-15-59	23c. NAME OF CEMETERY OR CREMATORY SS Peter & Paul Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
---	----------------------	--	---

24. FUNERAL DIRECTOR Wingbermuehle	ADDRESS 3819 S. Grand Blvd.	25. DATE RECD. BY LOCAL REG. JAN 13 '59	REGISTRAR'S SIGNATURE <i>J. Carl Smith Mo</i>
---------------------------------------	--------------------------------	--	--

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 *[Handwritten Signature]*

Licensed Embalmer No. *4611*

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.