Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003264
STATE FILE NUMBER

FILED JAN 28 1959

Registration District No. 31[illegible] Primary Registration District No. 1003 Registrar's No. 295

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 ☐ No ☐

c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐

c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Jewish Hospital — Length of stay in lb

d. STREET ADDRESS (If outside, give location) 2109 3917 Palm St. — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Josephine Middle Last Martin

4. DATE OF DEATH Month January Day 8, Year 1959

5. SEX Female 3

6. COLOR OR RACE Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ / DIVORCED ☐

8. DATE OF BIRTH 6 Feb 1904

9. AGE (In years last birthday) 54 — 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 none

11. BIRTHPLACE (City and state or country) Penoke, Mississippi /

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Augustus Claiborn

13b. MOTHER'S MAIDEN NAME Nannie Parker

14. NAME OF HUSBAND OR WIFE John Martin

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. unknown

17. INFORMANT John Martin Address 3917 Palm St.

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~~ SARCOMA, Retroperitoneal — INTERVAL BETWEEN ONSET AND DEATH 11 mo.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) c̄ generalized metastasis.
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 158x

19. WAS AUTOPSY PERFORMED? YES ☐ 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 Feb. 58, to Jan. 59 and last saw her/him alive on 1/8/59
Death occurred at 8:00 pm m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Melvin L. Goldman, MD

22b. ADDRESS 634 N. Grand

22c. DATE SIGNED 1/9/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal

23b. DATE 12 Jan 1959

23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery

23d. LOCATION (City, town, or county) St. Louis County, (State) Mo.

24. FUNERAL DIRECTOR Atkins Bros. ADDRESS 3644 Finney Ave.

25. DATE RECD. BY LOCAL REG. JAN 10'59

26. REGISTRAR'S SIGNATURE J 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 John K. Cunningham

Licensed Embalmer No. 4476

P. O. Address 2405 Marcus Ave.

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.