Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-003391
STATE FILE NUMBER

FILED FEB 3 1959

Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2 537

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Homer G. Phillips — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 2102 Eugenia — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Flossie — Middle: — Last: Poe

4. DATE OF DEATH: Month 1 — Day 13 — Year 59

5. SEX: Female 3
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ 2 DIVORCED ☐
8. DATE OF BIRTH: 3/I/1897
9. AGE (In years last birthday): 61 — 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 or if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (City and state or country): Ark
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13a. FATHER'S NAME: Tom Sims
13b. MOTHER'S MAIDEN NAME: Sarah Cotey
14. NAME OF HUSBAND OR WIFE: Ziek Poe

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.: None
17. INFORMANT: Leola Griffin — Address: 4029 Labadie

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): carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 199.2
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 ☒ 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 12-28-58, to 1-13-59 and last saw her alive on 1-13-59
Death occurred at 10:30 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: [illegible] (Degree or title) M.D.
22b. ADDRESS: 2601 Whittier Street
22c. DATE SIGNED: 1-15-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: I/I9/59
23c. NAME OF CEMETERY OR CREMATORY: Greenwood Cemetery
23d. LOCATION (City, town, or county): St, Louis Co. (State): Mo.

24. FUNERAL DIRECTOR: Whitney Funeral Home — ADDRESS: 3882 Delmar
25. DATE RECD. BY LOCAL REG.: JAN 16 59
26. REGISTRAR'S SIGNATURE: J. Early Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 F. A. Green

Licensed Embalmer No. 2963

P. O. Address 4214 Delman

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.