

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007023

STATE FILE NUMBER

2 604

Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

FILED FEB 24 1959

300
-57
6
38C

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
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 Clayton 4452
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Lutheran Hospital		Length of stay in lb 2 weeks	d. STREET ADDRESS (If outside, give location) 7563 Buckingham Dr.
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First Middle Last Georgianna N. Darraugh			4. DATE OF DEATH Month Day Year January 18, 1959		
---	--	--	---	--	--

5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 17, 1894	9. AGE (In years last birthday) 64	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) Teacher	10b. KIND OF BUSINESS OR INDUSTRY Day School	11. BIRTHPLACE (City and state or country) Empire, Michigan	12. CITIZEN OF WHAT COUNTRY? USA
---	--	---	--

13a. FATHER'S NAME Alonzo Norconk	13b. MOTHER'S MAIDEN NAME Georgie Aylesworth	14. NAME OF HUSBAND OR WIFE Walter P. Darraugh
---	--	--

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. 490-28-6941	17. INFORMANT Walter P. Darraugh, 7563 Buckingham Dr.
--	---	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis with Cerebral Metastasis		INTERVAL BETWEEN ONSET AND DEATH 2 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Carcinoma of Cecum	15 months
	DUE TO (c) 157-0	
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 <input type="checkbox"/> NO <input checked="" 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.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20e. CITY, TOWN, OR LOCATION	COUNTY	STATE
---------------------------------------	--	------------------------------	--------	-------

20d. INJURY OCCURRED WHILE AT <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 Dec. 1957 to Jan 18, 1959 and last saw her alive on Jan 17, 1959 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 (Degree or title) Morris Herman M.D.	22b. ADDRESS 3701 Grand Square	22c. DATE SIGNED 4/18/59
---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 1-19-1959	23c. NAME OF CEMETERY OR CREMATORY Empire Cemetery	23d. LOCATION (City, town, or county) (State) Empire, Michigan
---	-------------------------------	--	--

24. FUNERAL DIRECTOR Hoffmeister Colonial Mortary	ADDRESS 6464 Chippewa Street, St. Louis	25. DATE RECD. BY LOCAL REG. JAN 19 '59	26. REGISTRAR'S SIGNATURE J. Carl Smith M.D.
---	---	---	--

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 *Lee C. Brunson*

Licensed Embalmer No. *4964*

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.