

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007229
STATE FILE NUMBER

FILED MAR 10 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **1882**

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		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION City Hosp. # 1		d. STREET ADDRESS 2870 McNair	
Length of stay in 1b 2 Wks.		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) Marie L. Holmes			4. DATE OF DEATH 2-22 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 Oct. 30 1898	9. AGE (In years last birthday) 60	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Mobile Ala.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Zeno L. Eason			14. MOTHER'S MAIDEN NAME Maude Martin		
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.	17. INFORMANT Address John Bryant 2870 McNair Ave.		

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 Cervix uteri		INTERVAL BETWEEN ONSET AND DEATH 8 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		171x
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? 2 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. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from 2/9/59 to 2/21/59 and last saw her him alive on 2/21/59 . Death occurred at 10:10 PM m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Leo U. Muehlman, M.D.			22b. ADDRESS 1515 LAFAYETTE AVE		22c. DATE SIGNED 2/22/59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 2-23-59	23c. NAME OF CEMETERY OR CREMATORY Kansas City Kansas		23d. LOCATION (City, town, or county) (State)
24. FUNERAL DIRECTOR ADDRESS Jos. P. Fendler Jr. 7128 Michigan			25. DATE RECD. BY LOCAL REG. FEB 23 '59		26. REGISTRAR'S SIGNATURE Roan Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

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56
26
2493

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Medical Certification

Disseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

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.....
W E Morris

Licensed Embalmer No. *30*

P. O. Address *St Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
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.