

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007573

STATE FILE NUMBER

1799

FILED MAR 10 1959

Registration District No.

Primary Registration District No.

Registrar's No.

300
-57

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Homer G. Phillips</u>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>4743 Greer</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle Last <u>Richardson</u>			4. DATE OF DEATH Month <u>2</u> Day <u>17</u> Year <u>59</u>		
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5. SEX <u>Female</u> <u>3</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3 April 1899</u>	9. AGE (In years last birthday) <u>59</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and state or country) <u>Biscoear Arkansas</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13a. FATHER'S NAME <u>Every Johnson</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Mitchell</u>	14. NAME OF HUSBAND OR WIFE <u>Dead</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>No</u>	17. INFORMANT <u>Mrs Thelma Pugh</u> Address <u>4743 Greer Ave</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Epidermoid Carcinoma of the Gallbladder with wide spread Metastasis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>undet.</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>155.1</u>		
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.)
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20c. TIME OF INJURY Hour _____ 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 _____
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21. I attended the deceased from <u>1-31-59</u> to <u>2-17-59</u> and last saw her alive on <u>2-17-59</u> Death occurred at <u>10:00</u> <u>A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>J. D. Richardson M.D.</u>	22b. ADDRESS <u>2601 Whittier Street</u>	22c. DATE SIGNED <u>2-18-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Railroad</u>	23b. DATE <u>2/20/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Spring Grove</u>	23d. LOCATION (City, town, or county) (State) <u>Haynes Arkansas</u>
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24. FUNERAL DIRECTOR <u>Herman J. Smith</u> ADDRESS <u>4247 N. Labadie</u>	25. DATE RECD. BY LOCAL REG. <u>FEB 19 '59</u>	26. REGISTRAR'S SIGNATURE <u>Loan Smith M.D.</u>
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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 *W. Claude Gordon*

Licensed Embalmer No. *3489*
P. O. Address *4575 Alder*

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.