

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007675

STATE FILE NUMBER

2 889

FILED MAR 2 1959 Registration District No. Primary Registration District No. Registrar No.

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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) St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis
c. FULL NAME OF (IF NOT in hospital, give location) HOMER G. PHILLIPS		Length of stay in lb	d. STREET ADDRESS 519 Ohio
			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) Robert Stevens			4. DATE OF DEATH Month 1 Day 23 Year 59			
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5. SEX Male 2	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-25-89	9. AGE (In years last birthday) 69	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) Laborer	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Missouri USA	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Lize Stevens	14. NAME OF HUSBAND OR WIFE Cassie Stevens
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input checked="" type="checkbox"/> or Unknown) (If yes, give war or dates of service) WW I	16. SOCIAL SECURITY NO.	17. INFORMANT Cassie Stevens-519 Ohio St. Address
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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) <i>adenocarcinoma - pancreas</i>		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) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>15 7 X</i>		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 Month, Day, Year 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

21. I attended the deceased from 1-13-59 to 1-23-59 and last saw ^{him} alive on 1-23-59
Death occurred at 4:25 A m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>F.O. Richards</i>	(Degree or title) M.D.	22b. ADDRESS 2601 Whittier Street	22c. DATE SIGNED 1-24-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 1-30-59	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City, town, or county) (State) Jefferson Barracks, Mo.
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24. FUNERAL DIRECTOR A.L. Beal Und.-4303 Delmar	ADDRESS	25. DATE RECD. BY LOCAL REG. JAN 26 '59	26. REGISTRAR'S SIGNATURE <i>J. Carl Smith Mo</i>
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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 *A. D. Richardson*

Licensed Embalmer No. *2928*

P. O. Address *City*

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.