

Health, Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-016342
STATE FILE NUMBER

Myrtle Petri
MAY 8 1959

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1140

300
-57

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Manchester</u>		c. CITY OR TOWN <u>Manchester</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Manchester Nursing</u>		d. STREET ADDRESS (If outside, give location) <u>Carmon Road-Rt. 2</u>	
Length of stay in lb <u>10 Wks.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Home</u> Middle <u>MYRTLE</u> Last <u>PETRI</u>			4. DATE OF DEATH Month <u>Apr.</u> Day <u>25</u> Year <u>1959</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sep. 15, 1888</u>
9. AGE (In years last birthday) <u>70</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>John Hoak</u>	
13b. MOTHER'S MAIDEN NAME <u>Emma Cooper</u>		14. NAME OF HUSBAND OR WIFE <u>Henry W. Petri</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>unk.</u>	
17. INFORMANT <u>Henry W. Petri</u>		Address <u>Carmon Rd.-Rt. 2</u>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
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) <u>Carcinoma of the lungs and bones</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Carcinoma of the Breast</u>	<u>4 years</u>
	DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pathological Fracture of Rt. Femur 170X</u>		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 <u>8:00 a.m.</u> Month <u>Apr.</u> Day <u>23</u> Year <u>59</u>		
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 <u>St. Louis Co. Mo.</u>
21. I attended the deceased from <u>Feb. 3, 59</u> to <u>April 23, 59</u> , and last saw her alive on <u>April 23, 59</u> Death occurred at <u>8:00 A.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <u>Robert W. Zaffey, M.D.</u> (Degree or title) <u>2</u>	22b. ADDRESS <u>Box 122, Newelton, Mo.</u>	22c. DATE SIGNED <u>4-25-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Apr. 28, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Burial Park</u>
23d. LOCATION (City, town, or county) <u>St. Louis Co. Mo.</u>		(State)

24. FUNERAL DIRECTOR <u>Kriegshauser 4228 S. Kingshighway</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>4-27-59</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy, MD</u>
--	---------	--	--

(Licensed Embalmer's Statement on Reverse Side)

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 *William B. White*

Licensed Embalmer No. *4291*

P. O. Address *Laurel, Md.*

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.