

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019560

STATE FILE NUMBER
Registration District No. 4434

FILED MAY 18 1959 Registration District No. Primary Registration District No.

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) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 4019 Cook	

3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH		
Mary Rice			Month 5 Day 2 Year 59		

5. SEX Female	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 8-18-1900	9. AGE (In years last birthday) 58	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) House Work	10b. KIND OF BUSINESS OR INDUSTRY Put Family	11. BIRTHPLACE (City and state or country) Hunting Tenn.	12. CITIZEN OF WHAT COUNTRY? U.S.A
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13a. FATHER'S NAME Unk	13b. MOTHER'S MARDEN NAME Unk	14. NAME OF HUSBAND OR WIFE Charles Rice
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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) NO	16. SOCIAL SECURITY NO. 490-36-8075	17. INFORMANT Address Charles Rice 4019 Cook Apt 19
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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) CEREBRAL THROMBOSIS		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) 332X		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) HYPERTENSIVE CARDIOVASCULAR DISEASE		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 4-28-59 to 5-2-59 and last saw her alive on 5-2-59 Death occurred at 8:20 P m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE Paul H. Laron (Degree or title) _____ M.D.	22b. ADDRESS 2601 Whittier Street	22c. DATE SIGNED 5-4-59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 5-6-59	23c. NAME OF CEMETERY OR CREMATORY Greenwood	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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24. FUNERAL DIRECTOR ADDRESS J. McClendon 4535 Washington	25. DATE RECD. BY LOCAL REG. MAY 5 '59	26. REGISTRAR'S SIGNATURE W. Earl Smith, M.D.
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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 *Arthur L. Hellier*

Licensed Embalmer No. *4291*
P. O. Address *3100 Eastern*

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.