

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-019635

STATE FILE NUMBER

2 5088

FILED JUN 4 1959

Registration District No.

Primary Registration District No.

Registration 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) 1519 Goode	
3. NAME OF DECEASED (Type or print) First Callie Middle Last Smith		4. DATE OF DEATH Month 5 Day 23 Year 59	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 September 1887
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pension		9b. KIND OF BUSINESS OR INDUSTRY	9c. AGE (In years last birthday) 71
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pension		10b. KIND OF BUSINESS OR INDUSTRY	10c. CITIZEN OF WHAT COUNTRY? U. S. A.
11a. FATHER'S NAME Wiley Jones		11b. MOTHER'S MAIDEN NAME Laura Dickson	11c. NAME OF HUSBAND OR WIFE Dead
12. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		13. SOCIAL SECURITY NO. No	14. INFORMANT Mrs Carrie Richardson 1519 Goode Ave
15. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS, PRIMARY SITE UNKNOWN, Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) 2 HEPATIC METASTASES. DUE TO (c) 1562			16. INTERVAL BETWEEN ONSET AND DEATH undet.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			17. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
18a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		18b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
19c. 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 5-19-59 to 5-23-59 and last saw her alive on 5-23-59 Death occurred at 1:24 P m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Paul H. Lamm (Degree or title) M.D.		22b. ADDRESS 2601 Whittier Street	22c. DATE SIGNED 5-25-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 5/27/59	23c. NAME OF CEMETERY OR CREMATORY Washington Park	23d. LOCATION (City, town, or county) (State) St. Louis County Missouri
24. FUNERAL DIRECTOR Herman J. Smith ADDRESS 4247/w Labadie Ave		25. DATE RECD. BY LOCAL REG. MAY 26 '59	26. REGISTRAR'S SIGNATURE Paul Smith M.D.

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 Gardner*

Licensed Embalmer No. *3489*

P. O. Address *4500 New York*

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.