

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-023085

STATE FILE NUMBER

FILED JUN 19 1959

Registration District No.

Primary Registration District No.

Registrar No. 4955

S. 300  
1-57

0  
S

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis,</b>		c. CITY OR TOWN <b>Florissant, 4051</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Louis-Little Rock Hospitals, Inc.</b>		Length of stay in lb <b>2 days</b>	
d. STREET ADDRESS <b>1070 Lindsay Lane</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Hyacinth</b> Middle <b>Edna</b> Last <b>Kirkendall</b>			4. DATE OF DEATH Month <b>May</b> Day <b>19</b> Year <b>1959.</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 6, 1902</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dental Assistant - City of St. Louis</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>City of St. Louis</b>	11. BIRTHPLACE (City and state or country) <b>Bismarck, Mo.</b>
13a. FATHER'S NAME <b>Thomas Davidson</b>		13b. MOTHER'S MAIDEN NAME <b>Mary (Unknown)</b>	14. NAME OF HUSBAND OR WIFE <b>Late Orian Kirkendall</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give dates of service) <b>no none</b>		16. SOCIAL SECURITY NO. <b>500-20-9421</b>	17. INFORMANT Address <b>Doris Lee Fuqua 1070 Lindsey Lane</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adeno Carcinoma of ovary with</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>wide spread abdominal metastasis</b> DUE TO (c) <b>16 mo.</b>			INTERVAL BETWEEN ONSET AND DEATH
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 checked="" type="checkbox"/> NO <input 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.		<b>1750</b>	
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 <b>May 17</b> , to <b>59 May 19, 1959</b> and last saw her/him alive on <b>May 19, 1959</b> Death occurred at <b>6:05 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Dress or title) <b>Royall W. Stein M.D.</b>		22b. ADDRESS <b>1755 South Grand Blvd.,</b>	22c. DATE SIGNED <b>5-21-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal (mtr) 5-22-1959</b>		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <b>Masonic Cemetery</b>
		23d. LOCATION (City, town, or county) <b>Bismarck, Mo.</b>	(State)
24. FUNERAL DIRECTOR <b>Kriegshauser Mortuary - Kingshighway -</b>		25. DATE RECD. BY LOCAL REG. <b>MAY 21 '59</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>

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

*Richard W. Stoverson*

Licensed Embalmer No. ....

4007

P. O. Address .....

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.