

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-023196

STATE FILE NUMBER  
REGISTRATION DISTRICT NO. 5877

FILED JUL 2 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 <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Incarinate Word Hosp</u>		d. STREET ADDRESS (If outside, give location) <u>5616 Milentz Ave.</u>	

3. NAME OF DECEASED (Type or print) First <u>Cleo</u> Middle <u>N.</u> Last <u>Middelkamp</u>			4. DATE OF DEATH Month <u>June</u> Day <u>21</u> Year <u>1959</u>			
---	--	--	--	--	--	--

5. SEX <u>F</u>	6. COLOR OR RACE <u>W</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>March 9, 1897</u>	9. AGE (In years last birthday) <u>62</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
--------------------	------------------------------	---	--	--	---	-----------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (City and state or country) <u>Pinckneyville, Ill.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
---	--	--	---

13a. FATHER'S NAME <u>Edwin Thorp</u>	13b. MOTHER'S MAIDEN NAME <u>Ada Brown</u>	14. NAME OF HUSBAND OR WIFE <u>George J. Middelkamp</u>
--	---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>No</u>	17. INFORMANT <u>George J. Middelkamp</u>	Address <u>5616 Milentz Ave.</u>
--	--------------------------------------	--	-------------------------------------

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>Hepatic Insufficiency</u> DUE TO (b) <u>Metastatic Adeno Carcinoma of Liver</u> DUE TO (c) <u>Adeno Carcinoma Rt Ovary</u>		INTERVAL BETWEEN ONSET AND DEATH <u>April 6, 1954</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>175.0</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>          </u> Month, Day, Year a.m. <u>          </u> p.m. <u>          </u>	

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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>          </u>	COUNTY <u>          </u>	STATE <u>          </u>
---	--	---	-----------------------------	----------------------------

21. I attended the deceased from April 1954 to June 21, 1959 and last saw her alive on June 20, 1959  
Death occurred at 7:00 A on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>Joseph E Carney MD</u>	(Degree or title)	22b. ADDRESS <u>906 Olive</u>	22c. DATE SIGNED <u>6-22-59</u>
---	-------------------	----------------------------------	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>June 23, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Warrenton Mo. Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Warrenton, Mo.</u>
---	-----------------------------------	---	--

24. FUNERAL DIRECTOR <u>Hoffmeister Colonial Mortuary</u> <u>6464 Chippewa St. St. Louis, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>JUN 22 '59</u>	26. REGISTRAR'S SIGNATURE <u>m/j Paul Smith, M.D.</u>
---	---	--

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *John Shlender* .....  
Licensed Embalmer No. *4194* .....  
P. O. Address *St. Louis* .....

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.