

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-042012

FILED VS DEC 7 1959

210641

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

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|---|--|---|--|
| 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, Mo.</u> | | c. CITY OR TOWN <u>St. Louis.</u> | |
| Length of stay in 1b | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Jewish Hospital</u> | | d. STREET ADDRESS (If outside, give location) <u>5623 Hiller Pl.</u> | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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|--|----------------------------------|---|--|--|--|--|
| 3. NAME OF DECEASED (Type or print) First <u>Evelyn</u> Middle <u>E.</u> Last <u>Hummel</u> | | | 4. DATE OF DEATH Month <u>November</u> Day <u>16</u> Year <u>1959</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>5/7/1902</u> | 9. AGE (last birthday) <u>57</u> | IF UNDER 1 YEAR Months _____ Days _____ | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u> | | 11. BIRTHPLACE (City and state or country) <u>Truesdale, Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
| 13a. FATHER'S NAME <u>August G. Hummel</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Eva Fredershausen</u> | | 14. NAME OF HUSBAND OR WIFE <u>Nil.</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>490-36-9209</u> | | 17. INFORMANT <u>Mrs. Virgil Halstenberg, 5623 Hiller, Pl.</u> | | |

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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: | | INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u> |
| IMMEDIATE CAUSE (a) <u>Metastatic Ca of Colon</u> | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>Cancer of colon</u> | |
| DUE TO (c) <u>153.8</u> | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown |

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|---|---|--|--------------------------|
| 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 _____ a.m. _____ p.m. | Month, Day, Year _____ | | |
| 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 <u>Sept 1956</u> to <u>11/16/59</u> and last saw <u>her</u> alive on <u>11/3/59</u> Death occurred at <u>8 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated. | | | |

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|---|------------------------------|--|---|--|
| 22a. SIGNATURE (Degree or title) <u>Margaret E. Leoni M.D.</u> | | 22b. ADDRESS <u>100 N. Euclid</u> | | 22c. DATE SIGNED <u>11/18/59</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | 23b. DATE <u>11-18-59</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u> | | 23d. LOCATION (City, town, or county) (State) <u>Warrenton, Mo.</u> |
| 24. FUNERAL DIRECTOR <u>F. W. Nieberg, Warrenton, Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>NOV 18 1959</u> | 26. REGISTRAR'S SIGNATURE <u>Loan Smith. M.D.</u> <u>S.P.</u> | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Arthur Haines*

Licensed Embalmer No. 4108

P. O. Address Alhambra

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.