URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

59-042134

FILED VS DEC 7 1959

MENDED

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 9825 STATE FILE NUMBER

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST LOUIS
Length of stay in 1b: 1 DAY
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: ST LUKES HOSP.
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MISSOURI
b. COUNTY: ST. LOUIS
c. CITY OR TOWN: MEHLVILLE
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): RT 8-BOX 1320
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First WINLA Middle M. Last LA ROSE
4. DATE OF DEATH: Month 10 Day 26 Year 59
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 7-28-96
9. AGE (last birthday): 63
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HR: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (City and state or country): ST FRANCIS CO. MO.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: ERASMUS EDWARDS
13b. MOTHER'S MAIDEN NAME: ODELLA, MARY
14. NAME OF HUSBAND ~~OR WIFE~~: WILLIAM LA ROSE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): NONE
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: WILLIAM LA ROSE
Address: RT 8-BOX 1320 MEHLVILLE, MO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic carcinoma of bile ducts.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): _____
DUE TO (c): 155.1
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)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 June 1954, to present and last saw her/him alive on 10/26/59
Death occurred at 3:40 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Richard Platner Parsons, M.D. (Degree or title)
22b. ADDRESS: 5525 Enright, St. Louis Mo.
22c. DATE SIGNED: 10/26/59

23a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
23b. DATE: 10-29-59
23c. NAME OF CEMETERY ~~OR CREMATORY~~: SUNSET BURIAL PARK
23d. LOCATION (City, town, or county) (State): AFFTON MO

24. FUNERAL DIRECTOR: FEY FUNERAL HOME
ADDRESS: MEHLVILLE MO
25. DATE RECD. BY LOCAL REG.: OCT. 27 1959
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D. C.R.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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 me

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed VE Morris

Signature of Student Embalmer

Licensed Embalmer No. 3360

P. O. Address St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comp 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.