URI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

FILED VS DEC 7 1959

59-042684

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 210824

ENDED

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, MISSOURI — Length of stay in 1b: Life

c. CITY OR TOWN Saint Louis — Inside Limits: Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL — Inside Limits: Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location) 4534 Ashland — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: MARY Middle: Last: WASHINGTON

4. DATE OF DEATH Month: NOVEMBER Day: 20 Year: 1959

5. SEX: Female

6. COLOR OR RACE: Negro

7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐

8. DATE OF BIRTH: 10/20/83

9. AGE (last birthday): 76 — 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: --

11. BIRTHPLACE (City and state or country): Cape Giradeau, Mo.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Henry Rowan

13b. MOTHER'S MAIDEN NAME: Annie Harrell

14. NAME OF HUSBAND OR WIFE: Lawrence Washington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) --

16. SOCIAL SECURITY NO.: none

17. INFORMANT Address: Rita Washington, 4534 Ashland

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
IMMEDIATE CAUSE (a)	ABDOMINAL CARCINOMATOSIS	4 MONTHS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	CARCINOMA OF BILIARY TREE	4 MONTHS
DUE TO (c)		

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 AUGUST 21, 1958, to NOV. 20, 1959 and last saw her/him alive on NOV. 18, 1959

Death occurred at 8:37 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): [signature] M. D.

22b. ADDRESS: BARNES HOSPITAL

22c. DATE SIGNED: 11/20/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE: 11/24/59

23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery

23d. LOCATION (City, town, or county) (State): St. Louis, Missouri

24. FUNERAL DIRECTOR ADDRESS: Chas. J. Gates, 4107 Finney

25. DATE RECD. BY LOCAL REG.: NOV 24 1959

26. REGISTRAR'S SIGNATURE: Earl Smith. M.D. MJB.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

BY AFFIDAVIT OF

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 m

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____
Signature of Student Embalmer

Signed Gaylor Swa

Licensed Embalmer No. 4580

P. O. Address 4107 Finney Ave

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.