

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 45 7 1 7

FILED VS JAN - 8 1960

211992

STATE FILE NUMBER

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

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>	Length of stay in 1b _____	c. CITY OR TOWN <u>St. Louis</u>	Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Homer G. Phillips</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>4222 E. Labadie</u>
Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <u>Wilma</u> Middle <u>R.</u> Last <u>Martin</u>			4. DATE OF DEATH Month <u>12</u> Day <u>23</u> Year <u>59</u>		
---	--	--	--	--	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</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>May 10, 1916</u>	9. AGE (last birthday) <u>43</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>13</u>	IF UNDER 24 HR Hours _____ Min. _____
----------------------	-------------------------------	---	--	--------------------------------------	----------------------------------	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and state or country) <u>Lake Providence La.</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
---	--	---	--	---	--	---	--

13a. FATHER'S NAME <u>Sidney Hurd</u>		13b. MOTHER'S MAIDEN NAME <u>Not Known</u>		14. NAME OF HUSBAND OR WIFE <u>Danzile Martin</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. _____		17. INFORMANT <u>Danzile Martin</u> Address <u>4222 E. Labadie</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>Carcinoma tosis</u>			INTERVAL BETWEEN ONSET AND DEATH _____		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b) _____		
			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 there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	

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 _____ to _____ and last saw her <u>her</u> alive on <u>12-23-59</u>				
Death occurred at <u>3:20</u> <u>a.</u> on the date stated above, and to the best of my knowledge, from the causes stated.				

22a. SIGNATURE (Degree or title) <u>W. Knolly W. Eburn, M.D.</u>		22b. ADDRESS <u>2601 N. Whittier</u>		22c. DATE SIGNED <u>12-27-59</u>
--	--	--------------------------------------	--	----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>12-28-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Washington Park</u>	23d. LOCATION (City, town, or county) <u>St. Louis</u>	(State) <u>Mo.</u>
--	---------------------------	---	--	--------------------

24. FUNERAL DIRECTOR ADDRESS <u>A. L. Beal Und. Co. 4303 Delmar</u>		25. DATE RECD. BY LOCAL REG. <u>DEC 28 1959</u>	26. REGISTRAR'S SIGNATURE <u>Coal Smith, M.D.</u>	
---	--	---	---	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

m. J. 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

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Arthur R. Heilbard

Licensed Embalmer No.

4228

P. O. Address

3100 East

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