

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

'59 0 46 1 3 5

FILED VS. JAN - 4 1960 317

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. 541 Registrar's No. 3421

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| 1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton</u> | | c. CITY OR TOWN <u>Kirkwood</u> | |
| Length of stay in 1b <u>2 DYS</u> | | Inside Limits <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis County Hosp.</u> | | d. STREET ADDRESS (If outside, give location) <u>242 Electric St.</u> | |
| Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Marie</u> Last <u>Fields</u> | | | 4. DATE OF DEATH Month <u>12</u> Day <u>19</u> Year <u>59</u> | | | |
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| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Col.</u> | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH <u>8/30 1908</u> | 9. AGE (last birthday) <u>51</u> | IF UNDER 1 YEAR Months <u>3</u> Days <u>17</u> Hours <u></u> Min. <u></u> | IF UNDER 24 HR Hours <u></u> Min. <u></u> |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u> | 10b. KIND OF BUSINESS OR INDUSTRY _____ | 11. BIRTHPLACE (City and state or country) <u>Jefferson City Mo.</u> | 12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u> |
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| 13a. FATHER'S NAME <u>Archie Fields</u> | 13b. MOTHER'S MAIDEN NAME <u>Sarah Young</u> | 14. NAME OF HUSBAND OR WIFE <u>Charlie Beck</u> |
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| 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. 487-30-5888</u> | 17. INFORMANT <u>Charlie Beck</u> Address <u>242 Electric</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: IMMEDIATE CAUSE (a) <u>Massive purulent peritonitis</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 days</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) <u>ruptured Left para ovarian cyst</u> | |
| | DUE TO (c) _____ | |

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| 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 type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input checked="" type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) _____ |
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| 20c. TIME OF INJURY _____ Hour _____ am. _____ p.m. _____ | Month, Day, Year _____ |
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|---|--|------------------------------------|--------------|-------------|
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 12-16-59 to 12-16-59 and last saw her alive on 12-16-59
Death occurred at 2:35 P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <u>John W. Hemphill</u> (Degree or title) _____ | 22b. ADDRESS <u>6015 S. Brentwood Clayton 5 Mo.</u> | 22c. DATE SIGNED <u>12/18</u> |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE <u>12/23/1959</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Father Dickson Cem.</u> | 23d. LOCATION (City, town, or county) <u>Crestwood</u> | (State) <u>Mo</u> |
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| 24. FUNERAL DIRECTOR <u>John W. Hemphill</u> ADDRESS <u>408 S. Fillmore</u> | 25. DATE RECD. BY LOCAL REG. <u>12-22-59</u> | 26. REGISTRAR'S SIGNATURE <u>John C. Muffley M.D.</u> |
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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 F. A. [Signature]

Licensed Embalmer No. 296

P. O. Address 4214 Delmar

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.