

DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-003279

FILED VS FEB 11 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 749** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b		c. CITY OR TOWN Ferguson		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Baptist Hosp.			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 921 Drummond Dr.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Eleanor Middle J. Last Curry			4. DATE OF DEATH Month Jan. Day 20, Year 1960				
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 10-25-1921	9. AGE (last birthday) 38	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) Moweaqua, Ill.		12. CITIZEN OF WHAT COUNTRY U. S./
13a. FATHER'S NAME Wayne Jacobs			13b. MOTHER'S MAIDEN NAME Laura Humphrey		14. NAME OF HUSBAND OR WIFE Harland G. Curry		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 356-10-0259	17. INFORMANT Address Harland G. Curry, Ferguson, MO.			
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 lung DUE TO (b) Adenocarcinoma of left breast. DUE TO (c) 170x Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 6 mo 2 yrs.
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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 Jan 1958 to 1-20-60 and last saw her alive on 1-19-60 Death occurred at 3:30 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE D.O. Fish, M.D. (Degree or title)				22b. ADDRESS 634 N. Grand Ave. St. Louis		22c. DATE SIGNED Mo	
23a. BURIAL, CREMATION, REMOVAL (Specify) Revolmat	23b. DATE 1-23-60	23c. NAME OF CEMETERY OR CREMATORY I.O.O.F. Cemetery		23d. LOCATION (City, town, or county) Moweaqua, Illinois (State)			
24. FUNERAL DIRECTOR ADDRESS White-Mullen Mortuary, Ferguson, Mo.				25. DATE RECD. BY LOCAL REG. JAN 21 1960	26. REGISTRAR'S SIGNATURE Loal Smith, M.D.		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

V.A.R.G.
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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 Reinhold K Lohmann

Licensed Embalmer No. 3395

P. O. Address St Louis 3

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