

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-004308

FILED VS FEB 1 1960

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STATE FILE NUMBER

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

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> b. COUNTY <u>St. Louis.</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Clayton, Mo.</u>		Length of stay in 1b <u>days</u>	c. CITY OR TOWN <u>Chesterfield</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Louis County Hospital</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Route # 1</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>ROSE</u> Middle <u>BAKER</u> Last _____			4. DATE OF DEATH Month <u>1</u> Day <u>19</u> Year <u>60</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>6/15/1892</u>	9. AGE (last birthday) <u>67</u>	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) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (City and state or country) <u>Pulaski County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Carl Wilken</u>		13b. MOTHER'S MAIDEN NAME <u>Nellie Burns</u>		14. NAME OF HUSBAND OR WIFE <u>James Baker</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. <u>Nil.</u>		17. INFORMANT <u>James Baker, Chester Field, Mo.</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>Carcinomatosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Known since July 1959</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>ovarian carcinoma primary</u>	
	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. <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 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 1-6-60 to 1-19-60 and last saw her alive on 1-19-60
Death occurred at 2:41 AM 1-19-60 m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Marshall June Red</u>		22b. ADDRESS <u>601 S. BRENTWOOD, CLAYTON</u>		22c. DATE SIGNED <u>1-19-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>1-21-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Seaton Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Maries County, Mo.</u>	

24. FUNERAL DIRECTOR <u>Albert H. Hoppe Inc., 4700 Washington, Blvd.</u>	ADDRESS <u>1-20-60</u>	25. DATE RECD. BY LOCAL REG. <u>1-20-60</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>
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BY AFFIDAVIT OF DOCUMENT 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
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John M. Mankley

Licensed Embalmer No. 3643

P. O. Address St. Louis

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.