URI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS MAR 8 1960

60-008627

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 2 2295

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Homer G. Phillips
Inside Limits: Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 4489 Washington
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Florence; Middle: ; Last: Mitchell

4. DATE OF DEATH: Month: 2; Day: 25; Year: 60

5. SEX: FeMale

6. COLOR OR RACE: Negro

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH: 3/24/19

9. AGE (last birthday): 40

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): St. Louis, Mo.

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

13a. FATHER'S NAME: unknown

13b. MOTHER'S MAIDEN NAME: unknown

14. NAME OF HUSBAND OR WIFE: Clifton Mitchell

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.: unknown

17. INFORMANT: Clifton Mitchell
Address: 4479 Washington

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Cervix
INTERVAL BETWEEN ONSET AND DEATH: Undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 171X

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 1-4-60, to 2-25-60 and last saw her/him alive on 2-25-60
Death occurred at 10:15 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Samuel E. Hamm, M.D.

22b. ADDRESS: 2601 N. Whittier St.

22c. DATE SIGNED: 2-25-60

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

23b. DATE: 3/1/60

23c. NAME OF CEMETERY OR CREMATORY: Washington Park

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

24. FUNERAL DIRECTOR: Charles J. Gates
ADDRESS: 4107 Finney

25. DATE RECD. BY LOCAL REG.: FEB 27 1960

26. REGISTRAR'S SIGNATURE: [illegible] M.D.
T.P.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

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 Geoffrey Swan

Licensed Embalmer No. 45 80

P. O. Address 4107 Fe

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