

**URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS MAY 2 1960**

**=60-017275**

**2 4104**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

ENDED

<b>1. PLACE OF DEATH</b> a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St Louis</u> Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4855 Fountain</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY _____ c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>4855 Fountain</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Charlett</u> Middle <u>-</u> Last <u>Roberts</u>			<b>4. DATE OF DEATH</b> Month <u>4</u> Day <u>11</u> Year <u>60</u>		
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>Colored</u>	<b>7. Married</b> <input type="checkbox"/> <b>Never Married</b> <input type="checkbox"/> <b>Widowed</b> <input checked="" type="checkbox"/> <b>Divorced</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>July 30 1886</u>	<b>9. AGE (last birthday)</b> <u>73</u>	<b>IF UNDER 1 YEAR</b> Months _____ Days _____ <b>IF UNDER 24 HR</b> Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>labor</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>maid</u>		<b>11. BIRTHPLACE</b> (City and state or country) <u>Bowling Green Ky</u>	
<b>12. CITIZEN OF WHAT COUNTRY</b> <u>U.S.A.</u>		<b>13a. FATHER'S NAME</b> <u>Unknown</u>		<b>13b. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>	
<b>14. NAME OF HUSBAND OR WIFE</b> _____		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>487-36-7316</u>	
<b>17. INFORMANT</b> <u>Margaret Foxwell</u>		<b>Address</b> <u>4855 Fountain</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inanition</u> DUE TO (b) <u>Carcinoma of Left Breast, Metastatic</u> DUE TO (c) <u>170X</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. _____ 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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. ACCIDENT</b> <input type="checkbox"/> <b>SUICIDE</b> <input type="checkbox"/> <b>HOMICIDE</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in PART I or PART II of item 18.) _____	
<b>20c. TIME OF INJURY</b> Hour _____ a.m. _____ p.m. Month, Day, Year _____		<b>20d. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
<b>20f. CITY, TOWN, OR LOCATION</b> _____		<b>COUNTY</b> _____		<b>STATE</b> _____	
<b>21. I attended the deceased from</b> <u>3-30-60</u> to <u>4-11-60</u> and last saw her/him alive on <u>4-10-60</u> Death occurred at <u>3:00</u> <u>P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
<b>22a. SIGNATURE</b> (Degree or title) <u>Charl. Fode, M.D.</u>			<b>22b. ADDRESS</b> <u>2801 N. Taylor</u>		<b>22c. DATE SIGNED</b> <u>4/12-60</u>
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> _____		<b>23b. DATE</b> <u>4-15-60</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Washington Park</u>		<b>23d. LOCATION</b> (City, town, or county) (State) <u>St Louis Co Mo</u>
<b>24. FUNERAL DIRECTOR</b> <u>S.J. Watson</u>			<b>ADDRESS</b> <u>2769 Chaular</u>		<b>DATE RECD. BY LOCAL REG.</b> <u>APR 14 1960</u>
<b>26. REGISTRAR'S SIGNATURE</b> <u>Earl Smith, M.D.</u> (Licensed Embalmer's Statement on Reverse Side)					

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

*James A Carter*

Licensed Embalmer No. *1165*

P. O. Address *St Louis*

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.