

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-017607

FILED VS MAY 6 1960

Registration District No. 317

Primary Registration District No. 541

Registrar's No. 1285

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY St. Louis				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 Clayton		Length of stay in 1b		c. CITY OR TOWN Hillsdale		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION D.O.A. County Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 6611 St. Louis Ave.			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Odessa Middle Holteclaw Last 				4. DATE OF DEATH Month 4 Day 18 Year 60					
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH 7-9-1900	9. AGE (last birthday) 59	IF UNDER 1 YEAR Months Days Hours Min. 	IF UNDER 24 HR Hours Min. 		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (City and state or country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY U.S.A.		
13a. FATHER'S NAME Lesley Van Kirk			13b. MOTHER'S MAIDEN NAME Lidia Nolan			14. NAME OF HUSBAND OR WIFE Divorced			
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. None		17. INFORMANT Address Mrs. Fern Bitza 9300 Guthrie				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Melanoma Malignant Growth							INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ 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			
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 _____, to _____ and last saw her/him alive on _____ Death occurred at 5:12P m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) John C. Murphy MD Asst. Health Commissioner				22b. ADDRESS 801 S. Brentwood Clayton, Mo.			22c. DATE SIGNED		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-21-1960	23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri				
24. FUNERAL DIRECTOR ADDRESS Jos. W. Clark F.H. 1125 Hodiamont			25. DATE RECD. BY LOCAL REG. 4-19-60		26. REGISTRAR'S SIGNATURE <i>John C. Murphy MD</i>				

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 Clarence M. Bell

Licensed Embalmer No. 4375
J. K. James
P. O. Address 23, 2

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.