

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-021233

FILED VS MAY 25 1960

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STATE FILE NUMBER

ENDED

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

6-22-60 nns

BY AFFIDAVIT OF Funeral Director

DOCUMENT

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>X</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u> c. FULL NAME OF HOSPITAL OR INSTITUTION <u>Booth Memorial Hospital</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>X</u> c. CITY OR TOWN <u>St. Louis</u> d. STREET ADDRESS (If outside, give location) <u>1820 Nebraska</u>	
3. NAME OF DECEASED (Type or print) First <u>Pearl</u> Middle <u>Crystal</u> Last <u>McAllister</u>			4. DATE OF DEATH Month <u>May</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>5-26-1913</u>	9. AGE (last birthday) <u>46</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Adjustable Eng. Cap Co.</u>		11. BIRTHPLACE (City and state or country) <u>Birch Tree, Mo.</u>
12. CITIZEN OF WHAT COUNTRY <u>United States</u>		13a. FATHER'S NAME <u>Luther Smotherman</u>		
13b. MOTHER'S MAIDEN NAME <u>Olive Hasty</u>		14. NAME OF HUSBAND OR WIFE <u>Lowe McAllister</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>499-14-2033</u>		17. INFORMANT <u>Guy E. Smotherman, Ashland, Nev.</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>Krukenberg's Tumor</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>1750</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>10 mo.</u>
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
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 <u>2-6-1960</u> to <u>5-11-1960</u> and last saw her him alive on <u>5-11-1960</u> Death occurred at <u>4:25 P.</u> on the date stated above, and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE <u>Leroy E. Ellison MD</u> (Degree or title)			22b. ADDRESS <u>3610 S. Broadway</u>	
22c. DATE SIGNED <u>5/11/60</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>5-11-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Local Corinth Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Montier, View, Mo</u>	
24. FUNERAL DIRECTOR <u>Albert H. Hoppe</u> ADDRESS <u>4700 Washington</u>		25. DATE RECD. BY LOCAL REG. <u>MAY 12 1960</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith, M.D.</u>

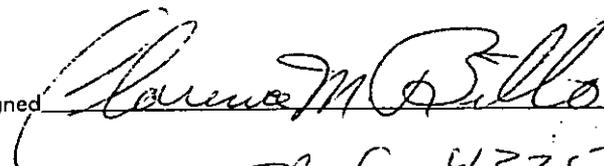
MJB.

**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 

Licensed Embalmer No. 4375  
P. O. Address St. Louis, Mo.

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.