...RI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS JUL 12 1960

-60-024562
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6403

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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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: 4334 West Belle
Inside Limits: Yes ☑ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo.
b. COUNTY
c. CITY OR TOWN: St. Louis
Inside Limits: Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location): 4334 West Belle
Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Addie Middle: Venable Last: Harris
4. DATE OF DEATH: Month 6 Day 21 Year 60
5. SEX: Female
6. COLOR OR RACE: Negro
7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐
8. DATE OF BIRTH: Abt 1879
9. AGE (last birthday): Abt. 81
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)
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country): Petersburg, Va.
12. CITIZEN OF WHAT COUNTRY: U. S. A.
13a. FATHER'S NAME: Richard Venable
13b. MOTHER'S MAIDEN NAME: Mary
14. NAME OF HUSBAND ~~OR WIFE~~: Edward Harris
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.: None
17. INFORMANT: Mrs. Gladys Vincent Address: 4334 West Belle

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
metastatic carcinoma
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) METASTATIC CARCINOMA — INTERVAL BETWEEN ONSET AND DEATH: 3 MO
papillary cystic adenocarcinoma left ovary
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) PAPILLARY CYSTIC ADENOCARCINOMA LEFT — 2 YRS
DUE TO (c) OVARY 1750
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 August 1950, to 21-June 60 and last saw her/him alive on 21-June 60
Death occurred at 3:35 p.m. 3:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE John S. Riley (Degree or title) M.D.
John S. Riley Jr. M.D.
22b. ADDRESS 4635 Easton
4635 Easton Ave, St. L.
22c. DATE SIGNED 22 June

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 6-24-60
23c. NAME OF CEMETERY OR CREMATORY: St. Peters Cemetery
23d. LOCATION (City, town, or county) (State): Lucas & Hunt Rd. Cty.

24. FUNERAL DIRECTOR: Gordon & English ADDRESS: 1123 N. Taylor
25. DATE RECD. BY LOCAL REG.: JUN 23 1960
26. REGISTRAR'S SIGNATURE: Noel Smith, M.D. MJS

(Licensed Embalmer's Statement on Reverse Side)

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_____ Signed W. Claude Gordo

Signature of Student Embalmer

Licensed Embalmer No. 3489

P. O. Address 1123 N. Ja

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.