

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-028202

LED VS AUG 8 1960 318

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7341

STATE FILE NUMBER

DED

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST LOUIS (CITY)</u>		Length of stay in 1b <u>52 DAYS</u>	c. CITY OR TOWN <u>ST LOUIS (CITY)</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>FAISCO HOSPITAL</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>325 N NEWSTEAD</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) <u>CATHERINE CHAPMAN</u>	First Middle Last	4. DATE OF DEATH <u>JULY 22 1960</u>	Month Day Year
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5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-17-1896</u>	9. AGE (last birthday) <u>64</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REARER RAILROAD CLEAK</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>LAWRENCE</u>	13b. MOTHER'S MAIDEN NAME <u>O'CONNOR</u>	14. NAME OF HUSBAND OR WIFE <u>UNMARRIED.</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>702-07-0012</u>	17. INFORMANT <u>LAWRENCE J. CHAPMAN 10 KINGS CT DR MO.</u>	Address <u>Ferguson</u>
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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>ADENOCARCINOMA OVARY</u> DUE TO (b) <u>WITH METASTASES.</u> DUE TO (c) <u>175.0</u>		INTERVAL BETWEEN ONSET AND DEATH <u>52 DAYS</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.)
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20c. TIME OF INJURY Hour e.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
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21. I attended the deceased from <u>MAY 28 1960</u> to <u>JULY 22 1960</u> and last saw her <u>alive on 8:05 PM</u> Death occurred at <u>8:30 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>[Signature] MD</u>	22b. ADDRESS <u>FAISCO HOSPITAL ST LOUIS MISSOURI</u>	22c. DATE SIGNED <u>7/22/60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>7-25-60</u>	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>	23d. LOCATION (City, town, or county) (State) <u>St Louis MO</u>
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24. FUNERAL DIRECTOR <u>Arthur J. Donnelly 3840 Lindell Blvd.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>JUL 23 1960</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith M.D.</u>
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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 Francis William

Licensed Embalmer No. 3564

P. O. Address 38400

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.