

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-028453

STATE FILE NUMBER

FILED VS JUL 22 1960 318 Primary Registration District No. 1003 Registrar's No. 7140

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St Louis</b>			Length of stay in 1b <b>1 hr</b>		c. CITY OR TOWN <b>St Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>City Hospital</b>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>2841 Chippewa</b>	
3. NAME OF DECEASED (Type or print) First <b>MAMIE</b> Middle <b>HUGHES</b> Last				4. DATE OF DEATH Month <b>July</b> Day <b>15</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6-6-1890</b>	9. AGE (last birthday) <b>70</b>	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) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>U S A</b>
13a. FATHER'S NAME <b>Joseph Allen</b>			13b. MOTHER'S MAIDEN NAME <b>Unknown</b>			14. NAME OF HUSBAND OR WIFE <b>Roy Hughes</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Roy Hughes 2841 Chippewa</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the Colon.</b> DUE TO (b) <b>Carcinoma of the Lungs.</b> DUE TO (c) <b>Cardiac Decompression.</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs. 5 months</b> <b>8 weeks.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>153.8</b>					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 <b>April 28, 1960</b> to <b>July 14, 1960</b> and last saw her <sup>him</sup> alive on <b>July 14, 1960</b> . Death occurred at <b>7:45A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Walter K. Hettich</b>				22b. ADDRESS <b>D.C. 3407 S. Grand Blvd.,</b>			22c. DATE SIGNED <b>7-15-60</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>July 18 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St Matthews Cem</b>		23d. LOCATION (City, town, or county) <b>St Louis</b>		STATE <b>Mo</b>	
24. FUNERAL DIRECTOR <b>Thomas Kutis 2906 Gravois</b>			25. DATE RECD. BY LOCAL REG. <b>JUL 18 1960</b>		26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b> <i>msc</i>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1-3 P.m. Friday

**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 O. Hill

Licensed Embalmer No. 4347

P. O. Address 2906 D

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.