

**FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**-60-033334**

**FILED MS AUG 16 1960**

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2249 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		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>Normandy</u>		c. CITY OR TOWN <u>St. Louis</u>	
Length of stay in 1b <u>4 days</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>Normandy Ostpath Hosp</u>		d. STREET ADDRESS (If outside, give location) <u>4832-Fyler Ave.</u>	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Virgie</u> Middle <u>Annis</u> Last <u>Sipe</u>			4. DATE OF DEATH Month <u>July</u> Day <u>26</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>10-13-82</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (City and state or country) <u>Elkins, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Milton Trickett</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>John Dcd.</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>None</u>		17. INFORMANT Address <u>James E. Sipe 4832 Fyler Ave.</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>Irreversible Shock - vasomotor collapse</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Surgery to relieve intestinal stbd.</u>			<u>24 hrs</u>
	DUE TO (c) <u>Generalized abdominal adenocarcinoma</u>			<u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>general debility, incontinence advanced age - adenocarcinoma</u>			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 Month, Day, Year a.m. p.m.		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>July 21</u> to <u>July 26</u> and last saw her him alive on <u>July 26</u> Death occurred at <u>4:30P</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			

22a. SIGNATURE (Degree or title) <u>R. Bloume</u>		22b. ADDRESS <u>3824 Natural Bridge</u>		22c. DATE SIGNED <u>7-27-60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>7-29-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fee Fee Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Bridgeton, Mo.</u>	
24. FUNERAL DIRECTOR <u>Pharmacia Bros</u> 2504-Woodson Rd - Overland - Mo.		25. DATE RECD. BY LOCAL REG. <u>7-27-60</u>	26. REGISTRAR'S SIGNATURE <u>John C. Murphy M.D.</u>	

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

*David L. Gibson*

Licensed Embalmer No. 3454

P. O. Address Overland

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.