

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 19 1960

318

1003

9899

60-040319

STATE FILE NUMBER

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)			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS Mo.				Length of stay: in 1b.		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF HOSPITAL OR INSTITUTION Mo. BAPTIST Hosp.				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS 3224 MIAMI	
3. NAME OF DECEASED (Type or print) First SOPHIA Middle Last TOPP				4. DATE OF DEATH Month OCT. Day 10 Year 1960			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH JAN. 29 1892	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and state or country) Mo.		9. AGE (last birthday) 68	
13a. FATHER'S NAME JOHN W. HUNT				13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE EMIL E. TOPP	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. None		17. INFORMANT EMIL E. TOPP. 3224 MIAMI	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Inanition DUE TO (b) Carcinomatosis of abdomen DUE TO (c) primary site in colon Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 153.8							INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.) 153.8	
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 October 1st to October 10 and last saw her/him alive on October 9, 1960 Death occurred at 12:30 PM on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Robert Thomassen M.D. (Degree or title)				22b. ADDRESS 100 N Euclid		22c. DATE OCT 11 1960	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE OCT. 13, 1960		23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cem.		23d. LOCATION (City, town, or county) ST. LOUIS Mo. (State)	
24. FUNERAL DIRECTOR Thomas Kates 2906 Gravier ADDRESS				25. DATE REG. BY LOCAL REG. OCT 11 1960		26. REGISTRAR'S SIGNATURE Loal Smith, M.D.	

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

Eleana Province

Licensed Embalmer No. *3403*

P. O. Address *2906 Jno*

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.