

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-040409

FILED VS OCT 24 1960

Registration District No. 317 Primary Registration District No. 531 Registrar's No. 3041

STATE FILE NUMBER

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <u>St. Louis</u>	Length of stay in 1b --	a. STATE <u>Mo.</u>	b. COUNTY <u>St. Louis</u>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>University City</u>	c. CITY OR TOWN <u>University City</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>6600 Washington Christian Home</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <u>6600 Washington Christian Home</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <u>MARY</u>	Middle <u>PALMER</u>	Last <u>HANCOCK</u>	4. DATE OF DEATH	Month <u>October</u>	Day <u>17,</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 checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>June 14, 1878</u>	9. AGE (last birthday) <u>82</u>	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) <u>at home</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
---	---	---	---

13a. FATHER'S NAME <u>William P. Hancock</u>	13b. MOTHER'S MAIDEN NAME <u>Helen P. Mason</u>	14. NAME OF HUSBAND OR WIFE <u>Never Married</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>493-07-7714</u>	17. INFORMANT <u>University City, Mo. Christian Home, 6600 Washington</u>
---	---	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH <u>5 YRS.</u>
IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	

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.)
---	---	--

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 1959 to OCT., 1960 and last saw her alive on SEPT. 19, 1960
Death occurred at 1:40 P. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>William A. Grogan, M.D.</u>	(Degree or title)	22b. ADDRESS <u>3720 WASHINGTON</u>	22c. DATE SIGNED <u>10/18/60</u>
--	-------------------	--	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE <u>Oct. 20, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Crematory</u>	23d. LOCATION (City, town, or county) <u>St. Louis County Mo.</u>
---	-----------------------------------	--	--

24. FUNERAL DIRECTOR <u>C.R. LUPTON & SONS, 7233 DELMAR BLVD.</u>	25. DATE RECD. BY LOCAL REG. <u>10-19-60</u>	26. REGISTRAR'S SIGNATURE <u>John E. Mumfley M.D.</u>
--	---	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. William Tibbs
3720 Washington

County

J.E. 1-8970

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Clarence A. Tibbs

Licensed Embalmer No. 40

P. O. Address St. Leo

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