

R.I. DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

LED VS NOV 2 1960

60-040577
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3038

1. PLACE OF DEATH a. COUNTY <u>Saint Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Normandy</u>		Length of stay in 1b <u>3 days</u>	c. CITY OR TOWN <u>Saint Louis</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 Osteopathic Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>3306 W. Milton</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u></u> Last <u>Davis</u>	4. DATE OF DEATH Month <u>Oct.</u> Day <u>17</u> Year <u>1960</u>
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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>11-5-1890</u>	9. AGE (last birthday) <u>69</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>	10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>John M. Wright</u>	13b. MOTHER'S MAIDEN NAME <u>Anna E. (Unknown)</u>	14. NAME OF HUSBAND OR WIFE <u>Deceased</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) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Allen Davis</u>	Address <u>4530 Springdale</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:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Decompensating Car-Pulmonal</u>		<u>3 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Metastatic Carcinomatosis both lungs</u>	<u>months</u>
	DUE TO (c) <u>Cirrhous Carcinoma right breast</u>	<u>months</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 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.)
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20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u></u>	Month, Day, Year: <u></u>
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u></u>	COUNTY <u></u>	STATE <u></u>
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21. I attended the deceased from 10/14/60 to 10-17-60 and last saw her/him alive on 10-17-60
Death occurred at 4:15 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>William D. McNewman</u>	(Degree or title) <u>Ed</u>	22b. ADDRESS <u>7811 Caywoodlot, Clayton 5, mo</u>	22c. DATE SIGNED <u>10-18-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>10-20-1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lake Charles Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Missouri</u>
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24. FUNERAL DIRECTOR <u>Jos. W. Clark F.H. 1125 Hodiamont</u>	ADDRESS <u></u>	25. DATE RECD. BY LOCAL REG. <u>10-19-60</u>	26. REGISTRAR'S SIGNATURE <u>Jos. B. Murphy 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

Robert M. Murray

Licensed Embalmer No. 3749

P. O. Address St. Louis, Mo.

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.