

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-044728

FILED VS NOV 17 1960

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3081

DED

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Ellisville		c. CITY OR TOWN St. Louis	
Length of stay in 1b 4 1/2 yrs.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Sunset Sanitarium		d. STREET ADDRESS (If outside, give location) 4721 Farlin Avenue	
Inside Limits 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) LOUISE M. HUDWALKER			4. DATE OF DEATH Month Oct. Day 22 Year 1960			
First	Middle	Last	Month	Day	Year	

5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9, 1894	9. AGE (last birthday) 66	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HR Months _____ Days _____ Hours _____ Min. _____	
-------------------------	----------------------------------	---	--	-------------------------------------	---	--	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house work	10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (City and state or country) Carlinville, Ill.	12. CITIZEN OF WHAT COUNTRY U.S.A.
--	--	--	--

13a. FATHER'S NAME George Ross	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE deceased
--	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT Edna Holland	Address 7740 Utica
---	--	--------------------------------------	------------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the Cecum with metastasis		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (c) 153.0	

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 **Sept. 30, 1958** to **Oct. 22, 1960** and last saw her alive on **Oct. 18, 1960**
Death occurred at **Ellisville, Mo. 12:45 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>George E. Smith M.D.</i>	(Degree or title)	22b. ADDRESS 325 N. Kirkwood Rd Kirkwood 22, Mo.	22c. DATE SIGNED 10/24/60
---	-------------------	--	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE Oct 25 1960	23c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cem.	23d. LOCATION (City, town, or county) St. Louis, Missouri
---	---------------------------------	---	---

24. FUNERAL DIRECTOR Bromschwig and Son	ADDRESS W Florissant 4746	25. DATE RECD. BY LOCAL REG. 10-24-60	26. REGISTRAR'S SIGNATURE <i>John W. Murphy M.D.</i>
---	-------------------------------------	---	---

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 J. W. Benley

Licensed Embalmer No. 305

P. O. Address St. Louis

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