

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048140

FILED VS JAN 5 1961 317

Registration District No. 541

Registrar's No. 3603

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON</u>		Length of stay in 1b <u>1 We.</u>		c. CITY OR TOWN <u>Wellsston, Mo.</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>St. Louis Co. Hosp.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>6220 Wells Ave.</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Battery</u> Last <u>Battery</u>				4. DATE OF DEATH Month <u>12</u> Day <u>12</u> Year <u>60</u>									
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>2/9/1894</u>		9. AGE (last birthday) <u>66</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR	
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>NONE</u>		11. BIRTHPLACE (City and state or country) <u>Walls, Mississippi</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					
13a. FATHER'S NAME <u>DAN McRAY</u>				13b. MOTHER'S MAIDEN NAME <u>Mollie Cox</u>				14. NAME OF HUSBAND OR WIFE <u>Ollie Battery</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>UNK.</u>		17. INFORMANT Address <u>Ollie Battery Wellsston, Mo.</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>Bronchiogenic carcinoma - left lung</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH			
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 <u>11-4/60</u> to <u>12/5/60</u> and last saw her ^{her} _{him} alive on <u>12/5/60</u> Death occurred at <u>10:07 PM</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE <u>Albert L. Howe M.D.</u> (Degree or title)				22b. ADDRESS <u>6015 Brentwood</u>				22c. DATE SIGNED <u>12/13/60</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>12/17/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Washington Park</u>				23d. LOCATION (City, town, or county) (State) <u>Beckley 34, Mo.</u>					
24. FUNERAL DIRECTOR <u>Ray Bros. 5625 Caeson, Kinloch</u> ADDRESS				25. DATE RECD. BY LOCAL REG. <u>12-14-60</u>		26. REGISTRAR'S SIGNATURE <u>John B. 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 Henry C. Williams

Licensed Embalmer No. 4781

P. O. Address 1205 Wall
St. Louis

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.