

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-048345

FILED VS JAN 9 1961

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 3750 STATE FILE NUMBER

DED

3123761

with metastases to the brain and kidneys.

BY AFFIDAVIT OF Attending Physician MEDICAL CERTIFICATION DOCUMENT

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>Koch</u>		Length of stay in 1b <u>32 days</u>		c. CITY OR TOWN <u>St. 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>Robert Koch Hospital</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>4005A. W. Belle</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle Last <u>Lewis</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>25</u> Year <u>1960</u>				
5. SEX <u>F.</u>	6. COLOR OR RACE <u>C.</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>9-15-00</u>	9. AGE (last birthday) <u>60</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>8</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nil</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Winsboro, La.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
13a. FATHER'S NAME <u>Ambus Heckard</u>			13b. MOTHER'S MAIDEN NAME <u>Mathews Lucewis</u>		14. NAME OF HUSBAND OR WIFE <u>Lewis, Hudson</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.		17. INFORMANT Address <u>Koch Hosp. RECORDS</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>Carcinoma of the left lung with metastases to the brain and kidneys.</u> DUE TO (b) <u></u> DUE TO (c) <u></u> 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) <u>Carcinoma left lung metastatic?</u>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT / SUICIDE 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 <u></u> s.m. <u></u> p.m. <u></u> Month, Day, Year <u></u>		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>Nov 23, 1960</u> to <u>Dec 25, 1960</u> and last saw her alive on <u>Dec 25, 1960</u> Death occurred at <u>6:05</u> a.m. on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Azel R. Irons, M.D.</u>				22b. ADDRESS <u>Robert Koch Hospital Koch Mo</u>		22c. DATE SIGNED <u>12-27-60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>12-28-60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Booker Washington</u>		23d. LOCATION (City, town, or county) (State) <u>East St Louis Ill</u>			
24. FUNERAL DIRECTOR <u>D. J. Watson</u>		ADDRESS <u>2769 Chateaus</u>		25. DATE RECD. BY LOCAL REG. <u>12-27-60</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>			

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

James A. Carter

Licensed Embalmer No. _____

P. O. Address _____

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.