

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

318

1003

-61-019282

STATE FILE NUMBER

AMENDED

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **5182**

**FILED JUN 8 1961**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Length of stay in 1b	c. CITY OR TOWN <b>St. Louis</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>8443 Lowell</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>8443 Lowell</b>
			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <b>ELLA MAY MONTGOMERY</b>			4. DATE OF DEATH Month Day Year <b>May 31st, 1961</b>		
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5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8/9/97</b>	9. AGE (last birthday) <b>63</b>	IF UNDER 24 HR Months Days Hours Min.	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	11. BIRTHPLACE (City and state or country) <b>Silva, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>
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13a. FATHER'S NAME <b>Bill Campbell</b>	13b. MOTHER'S MAIDEN NAME <b>Mollie Bell</b>	14. NAME OF HUSBAND OR WIFE <b>Sylvester Montgomery</b>
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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) <b>no</b>	17. INFORMANT Address <b>Mary Lee McCann, 8443 Lowell</b>
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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: IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA, PRIMARY RECTUM</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 YEARS</b>
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	
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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.)
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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 <b>154x</b>	COUNTY	STATE
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21. I attended the deceased from <b>MARCH 1958</b> to <b>MAY 31, 1961</b> and last saw her alive on <b>MAY 31, 1961</b> Death occurred at <b>9:00 PM</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <i>R. V. Bradley</i> (Degree or title) <b>M. D.</b>	22b. ADDRESS <b>110 SOUTH CENTRAL, CLAYTON 5</b>	22c. DATE SIGNED <b>6/2/61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>6/3/61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Friedens Cemetery</b>	23d. LOCATION (City, town, or county) <b>St. Louis, Mo.</b>	(State)
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24. FUNERAL DIRECTOR <b>Emil J. Heitzenroeder, 8319 Hallsferry</b>	25. DATE RECD. BY LOCAL REG. <b>JUN 2 1961</b>	26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>
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DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

ITEM NO. SHOULD READ

INVESTIGATION

STATE OF MISSOURI

DEPARTMENT OF HEALTH

HEALTH OFFICER

X

HEALTH OFFICER

DATE, TIME

LOCATION

NAME

AGE

SEX

RACE

X

SEX

AGE

CAUSE

PLACE

DATE

LOCATION

DESCRIPTION

INITIALS

INITIALS

HEALTH OFFICER'S SIGNATURE

DATE

OR

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Harry E. Monroe*

Licensed Embalmer No. 4495

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.

DATE

INITIALS

STATE OF MISSOURI DEPARTMENT OF HEALTH