SSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

-61-019503
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4431

FILED MAY 19 1961

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | DOCUMENT | BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Missouri b. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri
Length of stay in 1b
c. CITY OR TOWN St. Louis, Missouri
Inside Limits Yes ☐ No ☐

c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Peoples Hospital
Inside Limits Yes ☐ No ☐
d. STREET ADDRESS 4714 Ashland Ave. (If rural, give location)
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: Flora Middle: Bell Last: Starks
4. DATE OF DEATH Month: May Day: 9 Year: 1961

5. SEX: Female
6. COLOR OR RACE: Negro
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 11/23/1895
9. AGE (last birthday): 65
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (City and state or country): La Granger, La
12. CITIZEN OF WHAT COUNTRY: U. S. A.

13a. FATHER'S NAME: Henry Taylor
13b. MOTHER'S MAIDEN NAME: Mattie Bell
14. NAME OF HUSBAND OR WIFE: Homer Starks

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ------
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Mrs. Dorthy Haynes
Address: 4714 Ashland Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Metastatic carcinoma
DUE TO (c) Carcinoma of breast
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
170x
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 2/1/61 to 5/9/61 and last saw her/him alive on 5/9/61
Death occurred at 12:55 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE R. Williams, M.D. (Degree or title)
22b. ADDRESS 4703 St. Louis Ave
22c. DATE SIGNED 5/9/61

23a. BURIAL, CREMATION, REMOVAL (Specify): Shipping
23b. DATE: 5/10/61
23c. NAME OF CEMETERY OR CREMATORY: Jeffersonville Ind.
23d. LOCATION (City, town, or county) (State): Jeffersonville, Indiana

24. FUNERAL DIRECTOR: E. B. Loane
ADDRESS: 1221 North Grand
25. DATE RECD. BY LOCAL REG.: 5-9-1961
26. REGISTRAR'S SIGNATURE: Roan Smith, M.D.

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 Malvin Blackburn

Licensed Embalmer No. 3967

P. O. Address 1221 N. Ave

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.