

SOURCE DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-038856
STATE FILE NUMBER

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10114**

FILED NOV 8 1961

DATE AMENDED
12/7/61

Metastatic carcinoma to bone marrow--Primary not determined

Adenocarcinoma of bone marrow

DOCUMENT
BY AFFIDAVIT OF attending physician

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis MO.			Length of stay in 1b		c. CITY OR TOWN St. LOUIS		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION JEWISH HOSPITAL			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 530 N. UNION		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First KATE Middle HARRIS Last LADNEY				4. DATE OF DEATH Month 10 Day 30 Year 1961			
5. SEX FEMALE	6. COLOR OR RACE W.	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/3/97	9. AGE (last birthday) 64	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) AT HOME			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Jackson Tenn		12. CITIZEN OF WHAT COUNTRY
13a. FATHER'S NAME NATHAN HARRIS			13b. MOTHER'S MAIDEN NAME ANN STEINHOLTZ		14. NAME OF HUSBAND OR WIFE MILTON J. LADNEY		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. none		17. INFORMANT Address MILTON J. LADNEY 530 N. Union		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). DEATH WAS CAUSED BY: PART I. IMMEDIATE CAUSE (a) Adeno- of Metastatic Carcinoma to Bone Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Marrow- Primary- not- DUE TO (c) determined- 2002							INTERVAL BETWEEN ONSET AND DEATH 3 Months
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 type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 Month, Day, Year a.m. p.m.							
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 6 - 1961 to Oct 30 - 1961 and last saw her ^{her} alive on Oct 30 - 1961 Death occurred at 8 P m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) Herman M. Meyer M.D.				22b. ADDRESS 4409 West Pine			22c. DATE SIGNED 10/31/61
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE Nov. 1, 1961	23c. NAME OF CEMETERY OR CREMATORY Mt. Sinai		23d. LOCATION (City, town, or county) 8400 Gravois Ave		
24. FUNERAL DIRECTOR ADDRESS MAYER 4356 Lindell Blvd				25. DATE RECD. BY LOCAL REG. OCT 31 1961		26. REGISTRAR'S SIGNATURE Loed 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 Harvey Stahl
Licensed Embalmer No. 4596
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.