

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-003995

STATE FILE NUMBER

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **481**

1. PLACE OF DEATH
 a. COUNTY Missouri
 b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis Length of stay in 1b 2 months
 c. CITY OR TOWN St. Louis Inside Limits Yes No
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) 5523 Cabanne Reside on Farm Yes No

3. NAME OF DECEASED First Middle Last 4. DATE OF DEATH Month Day Year
 Carrie Jones 1 9 62

5. SEX Female 6. COLOR OR RACE Negro 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 2 Sept 1910 9. AGE (last birthday) 52
 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) Okolana, Mississippi 12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Anderson Burdine 13b. MOTHER'S MAIDEN NAME Mary Ford 14. NAME OF HUSBAND OR WIFE Deceased

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No No 16. SOCIAL SECURITY NO. Unknown 17. INFORMANT Address Donald Harvey 5523 Cabanne

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Metastatic Carcinoma of Uterus
 DUE TO (b) _____
 DUE TO (c) _____

CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. 174x
 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. 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 11-24-61 to 1-9-62 and last saw her ~~xxx~~ alive on 1-9-62
 Death occurred at 7:25 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Inscribe or title) 22b. ADDRESS 22c. DATE SIGNED
 [Signature] 2601 N. Whittier Street 1-10-62

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal 23b. DATE 15 Jan 1962 23c. NAME OF CEMETERY OR CREMATORY National Cemetery 23d. LOCATION (City, town, or county) Jefferson Bks. Mo. (State)

24. FUNERAL DIRECTOR ADDRESS 25. DATE RECD. BY LOCAL REG. 26. REGISTRAR'S SIGNATURE
 [Signature] 1221 North Grand Blvd. JAN 11 1962 [Signature] M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATE OF ILLINOIS
DEPARTMENT OF HEALTH

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 Oliver E Cramble, Student Embalmer No. 682

working under my personal supervision.

Student Oliver E Cramble Signed Melvin Blackman
Signature of Student Embalmer

Licensed Embalmer No. 3967

P. O. Address 1221 N. Grand

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.