

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **25864**
7103

FILED JUL 31 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY D				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY 0502				
b. CITY OR TOWN ST. Louis Mo.		c. LENGTH OF STAY (in this place) 19 DAYS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN FESTUS		d. STREET ADDRESS (If rural, give location) 826 No. Mill		
3. NAME OF DECEASED (Type or Print) a. (First) MARY b. (Middle) ELIZABETH c. (Last) HANCOCK			4. DATE OF DEATH 7-23-52		5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE		8. DATE OF BIRTH 7-25-42		9. AGE (In years last birthday) 9 1/2		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		
10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) ST. Louis Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Wallace R Hancock		
13b. MOTHER'S MAIDEN NAME MARY ELLEN ENGLAND		14. NAME OF HUSBAND OR WIFE None		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		
17. INFORMANT'S SIGNATURE OR NAME J. Egan		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) Hypoplastic anemia		19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 293X		
22. I hereby certify that I attended the deceased from 7-4 , 19 52 , to 7-23 , 19 52 that I last saw the deceased alive on 7-23 , 19 52 , and that death occurred at 12:20pm. , from the causes and on the date stated above.								
23a. SIGNATURE Wm. H. K. Highberg MD (Degree or title)				23b. ADDRESS _____		23c. DATE SIGNED _____		
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 7-23-52		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) Festus, Mo.		
DATE REC'D BY LOCAL REG. JUL 23 1952		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Vinyard Funeral Home, Festus, Mo.		ADDRESS _____		

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JUN 11 1954

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
Student Embalmer

Signed.....

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 this body is not embalmed, fact should be so stated above.