

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21056**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5399**

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, write RURAL and give town) St. Louis 0		c. CITY OR TOWN St. Louis	
c. LENGTH OF STAY (In this place)		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		e. STREET ADDRESS (If rural, give location) 21 1935 Carr	

3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year)	
a. (First) Bettie	b. (Middle) Bettie	c. (Last) Ollie	June 13, 1954

5. SEX F 3	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow 2	8. DATE OF BIRTH March 3, 1909	9. AGE (In years last birthday) 45	IF UNDER 1 YEAR Months 3	IF UNDER 6 HRS. Hours Min.
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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 Foreign Country) Wilson, Arkansas	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME Gabe Ollie	13b. MOTHER'S MAIDEN NAME unknown	14. NAME OF HUSBAND OR WIFE unknown
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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) no	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Will Hawkins, 1935a Carr	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Undt
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Cervix with Metastasis		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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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? 171X
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22. I hereby certify that I attended the deceased from **May 26, 1954**, to **June 13, 1954**, that I last saw the deceased alive on **June 13, 1954** and that death occurred at **3:25 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) William Hawkins, M.D.	23b. ADDRESS 2601 N. Whittier	23c. DATE SIGNED 6/14/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Ship	24b. DATE June 17, 1954	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Oceola, Arkansas
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DATE REC'D BY LOCAL REG. JUN 16 1954	REGISTRAR'S SIGNATURE Carl Smith M.D. E. Blouse	25. FUNERAL DIRECTOR'S SIGNATURE E. Blouse	ADDRESS 1221 N. Grand
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 Blackman*.....

Licensed Embalmer No. *39*.....

P. O. Address *1221 N.*.....

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.