

FILED JUL 26 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 24265

5889

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>5889</b>							
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____									
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>							
d. FULL NAME OF HOSPITAL OR INSTITUTION: <b>Homer G. Phillips Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>2219 2345 Chestnut St.</b>									
3. NAME OF DECEASED (Type or Print) a. (First) <b>Sophia</b>			b. (Middle) _____		c. (Last) <b>Betts</b>		4. DATE OF DEATH (Month) <b>6</b> (Day) <b>28</b> (Year) <b>54</b>						
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Col</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>Sept-1893</b>		9. AGE (In years last birthday) <b>60</b> # UNDER 1 YEAR Months _____ # UNDER 1 HR. Hours _____ Min. _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nil</b>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <b>Columbus, Miss</b>			12. CITIZEN OF WHAT COUNTRY? _____					
13a. FATHER'S NAME <b>Chas. Bailey</b>			13b. MOTHER'S MAIDEN NAME <b>Flossie (Unk)</b>			14. NAME OF HUSBAND OR WIFE _____							
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. _____		17. INFORMANT'S SIGNATURE OR NAME <b>Walter Betts, 3412a Walnut St.</b> ADDRESS _____								
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.				I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Adeno Carcinoma of Uterus with Metastasis to Vagina and Umbilicus</b>				MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>Undt.</b>			
ANTECEDENT CAUSES				DUE TO (b) _____				DUE TO (c) _____					
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				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"/>					
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 <b>174x</b>	
22. I hereby certify that I attended the deceased from <b>4-30</b> , 19 <b>54</b> , to <b>6-28</b> , 19 <b>54</b> , that I last saw the deceased alive on <b>6-28</b> , 19 <b>54</b> , and that death occurred at <b>6:45 AM</b> from the causes and on the date stated above.													
23a. SIGNATURE <b>William Tamm</b>				(Degree or title) <b>M.D.</b>				23b. ADDRESS <b>2601 N. Whittier</b>		23c. DATE SIGNED <b>6-28-54</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>6/3/54</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>		24d. LOCATION (City, town, or county) <b>St. Louis County, Mo</b> (State) _____							
DATE REC'D BY LOCAL REG. <b>JUN 30 1954</b>		REGISTRAR'S SIGNATURE <b>Carl Smith MD</b>				25. FUNERAL DIRECTOR'S SIGNATURE <b>R. M. C. Green</b> ADDRESS <b>4060 Washington</b>							

(Licensed Embalmer's Statement on Reverse Side)

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... *Melvin E. Green* .....

Licensed Embalmer No. *442*

P. O. Address *St. Louis*

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.