

10041

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED MAR 31 1955

2419

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

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 township) OR TOWN St. Louis, Mo.		c. CITY OR TOWN St. Louis,	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Old Faith Hospital		STREET ADDRESS (If rural, give location) 5 5829 Enright Ave.	

3. NAME OF DECEASED (Type or Print)	a. (First) Maggie	b. (Middle) J.	c. (Last) Pemberton	4. DATE OF DEATH (Month) (Day) (Year) Mar. 16, 1955
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 12, 1895	9. AGE (In years last birthday) 59	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 1 HRS. Hours	IF UNDER 15 MIN. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home,		11. BIRTHPLACE (City and State or Foreign Country) Gallatin County, Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		

13a. FATHER'S NAME Monroe Morris	13b. MOTHER'S MAIDEN NAME Nanne Prather	14. NAME OF HUSBAND OR WIFE Clarence Pemberton
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) No.	16. SOCIAL SECURITY NO. Nil.	17. INFORMANT'S SIGNATURE OR NAME Clarence Pemberton, 5829 Enright Ave.	ADDRESS 5829 Enright Ave.
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Adenocarcinoma of ovary		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) None DUE TO (c) None		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Adenocarcinoma of both ovaries	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <input checked="" type="checkbox"/>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 175 X
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. <input checked="" type="checkbox"/>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 175 X

22. I hereby certify that I attended the deceased from 10-1, 1954 to 3/16, 1955, that I last saw the deceased alive on 3/15, 1955, and that death occurred at 3:27 pm, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) James J. Pridy M.D.	23b. ADDRESS 730 Hawthorn St.	23c. DATE SIGNED 3/16/55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 3-16-55	24c. NAME OF CEMETERY OR CREMATORY Cottage Grove Cem.	24d. LOCATION (City, town, or county) (State) Equality, Ill.
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DATE REC'D BY LOCAL REG. MAR 16 1955	REGISTRAR'S SIGNATURE Carl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington.
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10.48

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, ~~on~~ by Student Embalmer No. working under my personal supervision..

Student
Signature of Student Embalmer

Signed *Elmer R. Powell*

Licensed Embalmer No. *407*

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.