

No. 300  
10.48

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

10119

FILED MAR 31 1955

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State File No. ....

Registrar's No. 2689

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No. ....	
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>				STREET ADDRESS (If rural, give location) <b>2924 Sheridan</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Mary</b>		b. (Middle) _____		c. (Last) <b>Robinson</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>3 23 55</b>	
5. SEX <b>female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED, NEVER MARRIED, <input checked="" type="checkbox"/> WIDOWED, <input type="checkbox"/> DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>4 July 1897</b>	
9. AGE (In years last birthday) <b>57</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Mississippi</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13a. FATHER'S NAME <b>Not Known</b>		13b. MOTHER'S MAIDEN NAME <b>Not Known</b>		14. NAME OF HUSBAND OR WIFE <b>XXXXXXXXXX XXXXXX XXXXXX</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Dorsey Blairr 2924 Sheridan</b>			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of Stomach with Metastasis to Peritoneum with Ascites</b>  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.				INTERVAL BETWEEN ONSET AND DEATH <b>Undt.</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) _____ m.		21e. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>151X</b>			
22. I hereby certify that I attended the deceased from <b>3-8-55</b> , 19 <b>55</b> , to <b>3-23</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>3-23-55</b> , 19 <b>55</b> , and that death occurred at <b>8:45 A</b> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Edw. B. Williams M.D.</b>				23b. ADDRESS <b>2601 N. Whittier</b>		23c. DATE SIGNED <b>3-24-55</b>	
24a. BURIAL, CREMATION REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>29 Mar. 55</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Oakdale Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo.</b>	
DATE REC'D BY LOCAL REG. <b>MAR 25 1955</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Reliable Funeral Sys. 1221 N. Taylor</b>			

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

(Licensed Embalmer's Statement on Reverse Side)

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 *Paul V Freeman*

Licensed Embalmer No. *46*

P. O. Address *47297*

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.