

FILED MAY 26 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

16618

BIRTH NO. .... REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **4438**

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 town(ship)) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St Louis, Mo.</b>	
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"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Homer G. Phillips Hospital</b>		STREET ADDRESS (If rural, give location) <b>27 2918 Lucas</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>Ella</b>		b. (Middle)	
c. (Last) <b>Fitzpatrick</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>5 17 55</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH <b>Not known</b>	
9. AGE (in years last birthday) <b>About 74</b>		IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign Country) <b>Ripley Tenn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13a. FATHER'S NAME <b>George Halliburton</b>		13b. MOTHER'S MAIDEN NAME <b>Charlotte Boyed</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) <b>No</b>	
16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Martha Gause</b>	
ADDRESS <b>2918 Lucas Ave</b>		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <b>MEDICAL CERTIFICATION</b>	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of Breast</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Undt.</b>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES 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. <b>Metastases</b>		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>170X</b>	
22. I hereby certify that I attended the deceased from <b>5-9</b> , 19 <b>55</b> , to <b>5-17</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>5-17</b> , 19 <b>55</b> , and that death occurred at <b>7:50 p.m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <b>Frank O. Richards, M.D.</b>		23b. ADDRESS <b>2601 N. Whittier</b>	
23c. DATE SIGNED <b>5-18-55</b>		24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	
24b. DATE <b>5-23-55</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>	
24d. LOCATION (City, town, or county) (State) <b>St Louis, Mo.</b>		DATE REC'D BY LOCAL REG. <b>MAY 20 1955</b>	
REGISTRAR'S SIGNATURE <b>J. East Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>A. L. Beal Und Co.</b>	
ADDRESS <b>4303 Delmar</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.....

*John K. Cunningham*

Licensed Embalmer No. 404

P. O. Address 4700 1/2

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.