

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 29 1955

State File No. **30598**
REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **7696**

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|--|--|---|-------------------------|---|--|
| 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) St. Louis | | c. LENGTH OF STAY (In this place) | | c. CITY OR TOWN St. Louis 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 2721 Dayton Street | | e. STREET ADDRESS (If rural, give location) 2721 Dayton Street | | | |
| 3. NAME OF DECEASED (Type or Print) LIZZIE | | | a. (First) | | b. (Middle) |
| | | | c. (Last) BISHOP | | 4. DATE OF DEATH (Month) (Day) (Year) Aug 29 1955 |
| 5. SEX Female | | 6. COLOR OR RACE Col | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | |
| 8. DATE OF BIRTH July 7 1896 | | 9. AGE (In years last birthday) 59 | | IF UNDER 1 YEAR Months 1 Days 22 IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and State or Foreign Country) Port Gibson Miss | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13a. FATHER'S NAME Louis Brown | | 13b. MOTHER'S MAIDEN NAME Fannie Garrison | |
| 14. NAME OF HUSBAND OR WIFE Guffie Bishop | | 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. 493-24-3922 | |
| 17. INFORMANT'S SIGNATURE OR NAME Guffie Bishop | | ADDRESS 2721 Dayton St | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CARCINOMA OF RT. OVARY INTERVAL BETWEEN ONSET AND DEATH UNKNOWN | | | |
| *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 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. 175x | | 19a. DATE OF OPERATION 6-18-55 | | 19b. MAJOR FINDINGS OF OPERATION EPIDERMOID CARCINOMA RT. OVARY | |
| 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) (Min.) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | |
| 21f. HOW DID INJURY OCCUR? | | 22. I hereby certify that I attended the deceased from 8/20 , 19 55 , to 8/29 , 19 55 , that I last saw the deceased alive on 8/26 , 19 55 , and that death occurred at 1:40 p. m. , from the causes and on the date stated above. | | | |
| 23a. SIGNATURE Chas. P. Forder, M.D. | | (Degree or title) | | 23b. ADDRESS 274 1/2 Franklin Avenue | |
| 23c. DATE SIGNED 8/30-55 | | 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24b. DATE Sept 2 1955 | |
| 24c. NAME OF CEMETERY OR CREMATORY Washington Park | | 24d. LOCATION (City, town, or county) (State) St. Louis, Co. Mo | | | |
| DATE REC'D BY LOCAL REG. SEP 1 1955 | | REGISTRAR'S SIGNATURE J. Carl Smith | | 25. FUNERAL DIRECTOR'S SIGNATURE J.H. Randle & Son | |
| ADDRESS 3133 Bell Avenue | | (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.....
J. J. Statts

Licensed Embalmer No. *269*
P. O. Address *276 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.