

Health, Welfare & Public Service
 300
 1-56
 Director, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.
 'USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE'

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

FILED SEP 6 1956

318

1003

28428

STATE FILE NUMBER

7133

Registration District No. Primary Registration District No. 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, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL INSTITUTION ST. LOUIS CITY HOSPITAL #1.		Length of stay in lb 15 Years		d. STREET ADDRESS 23 2407 A South 11th		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MIDDLE Last DELLA GIPSON				4. DATE OF DEATH Month Day Year AUG 1, 1956					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-11-1894		9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (City and state or country) Charleston, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Wallace Henry				14. MOTHER'S MAIDEN NAME Jennie Henderson					
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. ?		17. INFORMANT Address Edna Beardsley, 2407 S. 11th.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatosis, primary cervix</i> DUE TO (b) _____ DUE TO (c) <i>171x</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 3		
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.									
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from 7/27/56 to 8/1/56 and last saw her alive on 8/1/56 Death occurred at 1:35 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <i>Tracy F. Artzinger M.D.</i>				22b. ADDRESS 1515 LAFAYETTE AVE.		22c. DATE SIGNED 8/1/56.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 8-2-1956	23c. NAME OF CEMETERY OR CREMATORY Memorial Cemetery		23d. LOCATION (City, town, or county) (State) Sikeston, Missouri				
24. FUNERAL DIRECTOR ADDRESS McLAUGHLIN F.H., INC. Lafayette Ave. 2301				25. DATE RECD. BY LOCAL REG. AUG 1 1956		26. REGISTRAR'S SIGNATURE <i>Carl Smith M.D.</i>			

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.....
James R. Chapman

Licensed Embalmer No.....

P. O. Address.....
St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
(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.