

FILED JAN 29 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2558

Registration District No. 318 Primary Registration District No. 1003 STATE FILE NUMBER 397
Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hospital			Length of stay in lb 2/79	d. STREET ADDRESS (If outside, give location) 1612 S. Vandeventer			Reside on Form Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MIDDLE Last NETTIE L. BLACKWELL				4. DATE OF DEATH Month Day Year Jan. 13 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 24, 1899		9. AGE (In years last birthday) 57	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Nashville, Tenn.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Hunt				14. MOTHER'S MAIDEN NAME Martha Adcock			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. None		17. INFORMANT Address (Husband) Hugh Blackwell 1612 S. Vandeventer			
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>Carcinoma of Bladder</i>							INTERVAL BETWEEN ONSET AND DEATH <i>4 months</i>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic Pyelonephritis.</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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.) <i>181x</i>				
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 <i>March 1950</i> to <i>Jan 1957</i> and last saw her <i>alive</i> on <i>Jan 12, 1957</i> . Death occurred at <i>2:30 A.</i> m on the date stated above; and to the best of my knowledge from the causes stated.							
22a. SIGNATURE (Degree or title) <i>Walter W. Davis, M.D.</i>				22b. ADDRESS <i>539 N. Grand</i>		22c. DATE SIGNED <i>1/14/57</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>Jan. 16, 1957</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Hope Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>St. Louis Co. Mo.</i>		
24. FUNERAL DIRECTOR ADDRESS <i>Kriegshauser 4228 S. Kingshighway</i>				25. DATE RECD. BY LOCAL REG. <i>JAN 14 '57</i>		26. REGISTRAR'S SIGNATURE <i>Carl Smith M.D.</i>	

(Licensed Embalmer's Statement on Reverse Side)

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Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be entered. 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

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 *PW Storsand*

Licensed Embalmer No. *400*

P. O. Address

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.