

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6700

STATE FILE NUMBER

FILED FEB 25 1957

318

1003

1028

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		Inside Limits Yes <input 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 OR INSTITUTION 25 ST. LOUIS CITY HOSPITAL #1.			Length of stay in 1b #1.		d. STREET ADDRESS (If outside, give location) 21876 1201 S. Cardinal
3. NAME OF DECEASED (Type or print) First DELLA Middle Last TREATWELL			4. DATE OF DEATH Month JAN. Day 28, Year 1957		
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 17 1878	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil		10b. KIND OF BUSINESS OR INDUSTRY No	11. BIRTHPLACE (City and state or country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Coal Harris			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No No		16. SOCIAL SECURITY NO. No	17. INFORMANT Gussie Mahone 1201 S. Cardinal		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exhaustion - malnutrition DUE TO (b) Carcinomatosis DUE TO (c) Squamous cell Ca of Bronch 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 191x
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.)			
20c. TIME OF INJURY Hour a. m. Month, Day, Year 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 12/26/56 to 1/28/57 and last saw her/him alive on 1/28/57 Death occurred at 2:20 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Herbert Scott Lebl, M.D.			22b. ADDRESS 1515 LAFAYETTE AVE.		22c. DATE SIGNED 1/30/57.
23a. Burial, CREMATION, REMOVAL (Specify)		23b. DATE 2-4-57	23c. NAME OF CEMETERY OR CREMATORY Oakdale Cemetery;		23d. LOCATION (City, town, or county) (State) St. Louis County Mo.
24. FUNERAL DIRECTOR S. J. Watson		ADDRESS 2769 Chouteau		25. DATE RECD. BY LOCAL REG. FEB 1 '57.	26. REGISTRAR'S SIGNATURE J. Carl Smith M.D. S.P.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Death, coroner, etc. must use only standard non-removable ribbon. Coroner cannot certify to a death due to natural causes. Diseases in Part I must be casually related.

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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 Watson*
Licensed Embalmer No. *26*

P. O. Address *2719th*

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.