

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

8868
STATE FILE NUMBER
2841

FILED APR 15 1957

Registration District No. 318 Primary Registration District No. 1003 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 Johnson	
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 Knobnoster 0510 Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hospital		Length of stay in lb 2 Days	31 STREET ADDRESS (If outside, give location) 31 Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MARY Middle E Last BAILEY			4. DATE OF DEATH Month March Day 18 Year 1957
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 16, 1912
9. AGE (In years and birthday) 45		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Newton County Mo
13. FATHER'S NAME Edward Miller		14. MOTHER'S MAIDEN NAME Edith Yost	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 500-22-3638	17. INFORMANT Leroy Bailey Knobnoster Mo Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain tumor, Unipol, metastatic carcinoma - rt cerebellar hemisphere <i>carcinoma - rt cerebellar hemisphere</i> DUE TO (b) Carcinoma of rt breast. <i>carcinoma of rt breast</i> DUE TO (c) Carcinoma of rt breast. <i>carcinoma of rt breast</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 6 weeks
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 170x Month 3 Day 18 Year 57 a. m. p. m.		20d. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION 3-18-57 COUNTY 3-18-57 STATE	
21. I attended the deceased from 3-18-57 to 3-21-57 and last saw her alive on 3-18-57 Death occurred at 6:40 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Geo. E. Roulhac (Degree or title) M.D.		22b. ADDRESS 3720 Washington	
22c. DATE SIGNED 3-21-57		22d. ADDRESS 3720 Washington Mo	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3-22-57	
23c. NAME OF CEMETERY OR CREMATORY New Church		23d. LOCATION (City, town, or county) Johnson County Mo (State)	
24. FUNERAL DIRECTOR Albert H. Hoppe ADDRESS 4700 Washington		25. DATE RECD. BY LOCAL REG. MAR 23 '57	
26. REGISTRAR'S SIGNATURE J. Carl Smith M.D.			

MEDICAL CERTIFICATION

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

number

number

x

number

number

number

1951

APR 15 1951

Mr

John J. Jones

date

time

A.A.U.

number

of Home

number

with

with

number

200-22-3038

at

of

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. W. Bumbley*

Licensed Embalmer No. 365

P. O. Address St. Louis

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.