

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY - 8 1957

15330
STATE FILE NUMBER
4019

Registration District No. 318 Primary Registration District No. 1003

Registrar's Name

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) Inside Limits OR TOWN St. Louis 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) Length of stay in 1b 27 HOSPITAL OR INSTITUTION Homer G. Phillips		d. STREET (If outside, give location) Reside on Farm 211 ADDRESS 4266 West No. Market Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Ocelia (LEWIS) Stewart			4. DATE OF DEATH Month Day Year 4 25 57			
5. SEX Female 3	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-1-1905 21	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (City and state or country) TERRE HAUTE IND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME FRED ROSS			14. MOTHER'S MAIDEN NAME MATILDA JOHNSON			
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. 307-18-5215		17. INFORMANT Address MARIAN LANE		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Edema of Lung			INTERVAL BETWEEN ONSET AND DEATH undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) 200-1			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pleural Effusion - Lymphosarcoma			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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.)			
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.						
20d. INJURY OCCURRED WHILE AT <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 3-18-57 to 4-25-57 and last saw her alive on 4-25-57 Death occurred at 11:40 P m on the date stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE (Degree or title) Hugh Waters			22b. ADDRESS M.D. 2601 Whittier Street		22c. DATE SIGNED 4-26-57	

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 4/27/57	23c. NAME OF CEMETERY OR CREMATORY CRAWFORD, TERRE HAUTE, IND		23d. LOCATION (City, town, or county) (State) TERRE HAUTE IND
24. FUNERAL DIRECTOR ADDRESS EB KOONCE MORTUARY 1221 N. GRAND			25. DATE RECD. BY LOCAL REG. APR 27 '57	26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D. S.P.	

(Licensed Embalmer's Statement on Reverse Side)

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 causally related. Caroner 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 *Lawrence Creamer*

Licensed Embalmer No. *475*

P. O. Address *1221 N. Co. St.*

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.