

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED FEB 4 1958

47611  
STATE FILE NUMBER  
12506  
Registrar's No.

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis			c. CITY OR TOWN Brentwood 4511		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 39 Glennon Memorial Hospital		Length of stay in 1b	d. STREET ADDRESS 27 1610 E. Swan Circle		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Deborah Dianne Metcalf			4. DATE OF DEATH Month Day Year December 27, 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 Dec. 16, 1955	9. AGE (In years last birthday) 2	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Richmond Heights, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME Rowland R. Metcalf		13b. MOTHER'S MAIDEN NAME Barbara Lane		14. NAME OF HUSBAND OR WIFE None	
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. None	17. INFORMANT Address Rowland R. Metcalf, 1610 E. Swan Circle		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>internal hemorrhage</u> <u>leukemia, lymphatic, acute</u> DUE TO (b) <u>leukemia, lymphatic, acute</u> DUE TO (c) <u>leukemia, lymphatic, acute</u> CONDITIONS, if any, which gave rise to above cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>3 wks +</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chicken pox acute gastroenteritis</u>					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.)			
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.) 12-16-55	20f. CITY, TOWN, OR LOCATION COUNTY STATE Dec. 1957 12-23-57		
21. I attended the deceased from <u>Dec 16/1957</u> to <u>Dec 1957</u> and last saw <sup>her</sup> him alive on <u>Dec 23 1957</u> Death occurred at <u>4:00 am</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>C. K. Hamilton</u> (egree or title) <u>C. K. Hamilton M.D.</u>			22b. ADDRESS <u>35 N. Central</u> <u>3, N. Central Clayton</u>		22c. DATE SIGNED <u>12/27/57</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 12-27-57	23c. NAME OF CEMETERY OR CREMATORY Local		23d. LOCATION (City, town, or County) (State) Harrisburg, Ill.	
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, 4700 Washington Blvd.		25. DATE RECD. BY LOCAL REG. DEC 27 57	26. REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u> S.P.		

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.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Robert M. Murray* .....

Licensed Embalmer No. *3749*

P.O. Address *St. Louis, Mo*

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.