

Health,
Welfare
Public
Service

300
1-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
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.

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-007218
STATE FILE NUMBER
2080

FILED MAR 5 - 1958

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 <u>Missouri</u> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>27 Homer G. Phillips</u>		Length of stay in lb	d. STREET ADDRESS (If outside, give location) <u>21190 3656a Page</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Belle</u> Middle Last <u>Ford</u>			4. DATE OF DEATH Month <u>2</u> Day <u>19</u> Year <u>58</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>14 Oct. 1885</u>		9. AGE (In years last birthday) <u>72</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (City and state or country) <u>St. Louis Missouri</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13a. FATHER'S NAME <u>Robert Burke</u>		13b. MOTHER'S MAIDEN NAME <u>Fannie Jones</u>		
14. NAME OF HUSBAND OR WIFE <u>Dead</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. _____		
17. INFORMANT <u>Mr Eugene Steele</u>		Address <u>3656 Page Blvd</u>				
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>Rectal bleeding</u> DUE TO (b) <u>Carcinoma of sigmoid</u> DUE TO (c) _____ 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 <u>undet.</u>	
19. WAS AUTOPSY PERFORMED? <u>2</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<u>153.3</u>				
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 <u>2-16-58</u> to <u>2-19-58</u> and last saw her alive on <u>2-19-58</u> Death occurred at <u>10:00</u> <u>A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>Joseph M. D.</u> (Degree or title)			22b. ADDRESS <u>2601 Whittier Street</u>		22c. DATE SIGNED <u>2-20-58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>2/24/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenwoods Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo</u>	
24. FUNERAL DIRECTOR <u>Herman J. Smith</u>		ADDRESS <u>4247/w Labadie</u>		25. DATE RECD. BY LOCAL REG. <u>FEB 21 '58</u>	26. REGISTRAR'S SIGNATURE <u>J. Carl Smith, M.D.</u> <u>M. J. B.</u>	

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 *W. Claude Gordon*

Licensed Embalmer No. *34819*
P. O. Address *45 75 albu*

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.