

Health,  
Welfare  
Public  
Service

FILED FEB 28 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-008442

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 376

300  
-57

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Chesterfield, Mo.</u>		c. CITY OR TOWN <u>Chesterfield</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Rt. 1, Box 412</u>		d. STREET ADDRESS (If outside, give location) <u>Rt. 1, Box 412</u>	
Length of stay in 1b <u>LIFE</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>BETTY</u> Middle <u>JEAN</u> Last <u>WESTFALL</u>			4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>3</u> Year <u>1958</u>		
---	--	--	---	--	--

5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 27, 1931</u>	9. AGE (In years last birthday) <u>26</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
-------------------------	----------------------------------	---	--	--	--	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>	11. BIRTHPLACE (City and state or country) <u>Chesterfield, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
---	---	--	---

13a. FATHER'S NAME <u>Fred Westfall</u>	13b. MOTHER'S MAIDEN NAME <u>Rachel Johnson</u>	14. NAME OF HUSBAND OR WIFE <u>-- None</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. <u>None</u>	17. INFORMANT <u>Fred Westfall</u> Address <u>Rt. 1, Box 412 Chesterfield, Mo.</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>ADENOCARCINOMA OF BREAST WITH PULMONARY AND BONE METASTASES</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 MONTHS</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		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 _____ a.m. _____ 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 <u>JULY 16, 1957</u> to <u>JAN. 20, 1958</u> and last saw her/him alive on <u>JAN. 20, 1958</u> Death occurred at <u>A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE <u>C. E. Vermillion, M.D.</u> (Degree or title)	22b. ADDRESS <u>600 SOUTH KINGSHIGHWAY</u>	22c. DATE SIGNED <u>2/5/58</u>
---	---	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>2/8/58</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Union Baptist Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>West Gumbo, Missouri</u>
--	----------------------------	---	--

24. FUNERAL DIRECTOR <u>Charles J. Gates</u>	ADDRESS <u>4107 Finney</u>	25. DATE RECD. BY LOCAL REG. <u>2/7/58</u>	26. REGISTRAR'S SIGNATURE <u>Herbert R. Deane M.D.</u>
---	-------------------------------	---	---

(Licensed Embalmer's Statement on Reverse Side)

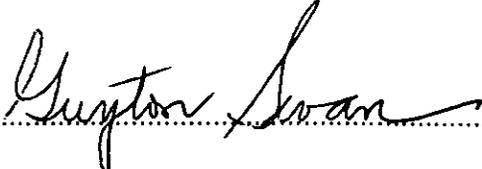
USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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  .....

Licensed Embalmer No. 4580 .....

P. O. Address.. 4107.. Finney.. Av

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.