Health, Welfare Public Service

300 -57

FILED MAR 21 1958

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-012501
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3051

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Louis Mo. — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Deaconess Hos'p — Length of stay in 1b 08

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY
c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 5630 Pershing — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First Frances Middle B. Last Wilson

4. DATE OF DEATH Month 3 Day 15 Year 58

5. SEX female

6. COLOR OR RACE White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH 4/28/95

9. AGE (In years last birthday) 62 — 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) Teacher

10b. KIND OF BUSINESS OR INDUSTRY Voice

11. BIRTHPLACE (City and state or country) Austin Texas

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Jacob(?) Block

13b. MOTHER'S MAIDEN NAME Unknown

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 491-34-5127

17. INFORMANT Mrs Thom Cox — Address 5856 Pershing Ave

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH 2 yrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Gastric Carcinoma — 2+ yrs.
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 151X

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 May 1, 1946 March 15, 1958 and last saw her/him alive on 3-15-58
Death occurred at 3:42 p.m. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) James P. Murphy, M.D.

22b. ADDRESS 634 N. Grand Blvd.

22c. DATE SIGNED 3-16-58.

23a. BURIAL, CREMATION, REMOVAL (Specify) cremation

23b. DATE 3/17/58

23c. NAME OF CEMETERY OR CREMATORY Oak Grove

23d. LOCATION (City, town, or county) 7800 St. Charles Rd (State) Mo

24. FUNERAL DIRECTOR Mayer — ADDRESS 4356 Lindell Blvd

25. DATE RECD. BY LOCAL REG. MAR 17 '58

26. REGISTRAR'S SIGNATURE J Carl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

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.

Not Embalmed.

Student .....
Signature of Student Embalmer

Signed Sol Mayer

Licensed Embalmer No. .....

P. O. Address 4356 Lin

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.