

FILED MAY 12 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-016308

STATE FILE NUMBER

4476

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 a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN Lemay	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Lutheran Hospital		d. STREET ADDRESS (If outside, give location) 3901 Mt. Olive	
3. NAME OF DECEASED (Type or print) First Middle Last Pearl Louise Phillips		4. DATE OF DEATH Month Day Year April 23 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 21, 1901
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) book binder		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis Co., Mo.
13a. FATHER'S NAME George Meister		13b. MOTHER'S MAIDEN NAME Lena Rick	14. NAME OF HUSBAND OR WIFE Roy L.
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.	17. INFORMANT Roy L Phillips Address 3901 Mt. Olive
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral metastatic carcinoma DUE TO (b) Probably Left Hypernephroma Unknown DUE TO (c) 180X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Fell out of bed - No cerebral or skull injury			INTERVAL BETWEEN ONSET AND DEATH 4-6 weeks
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.) Skull was X-rayed & Dr. Paul Scheerer was in consultation		
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 20f. CITY, TOWN, OR LOCATION COUNTY STATE St. Louis Co., Mo.		
20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21. I attended the deceased from <u>3/19/58</u> to <u>4/23/58</u> and last saw her alive on <u>4/23/58</u> Death occurred at <u>11:30 am</u> on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE Walter H. Noche M.D.	(Degree or title)	22b. ADDRESS 3108 S. Grand	22c. DATE SIGNED APR 24 58
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 4/26/1958	23c. NAME OF CEMETERY OR CREMATORY Lakewood Park Cem.	23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
24. FUNERAL DIRECTOR J L Ziegenhein & Sons 7027 Gravois	25. DATE RECD. BY LOCAL REG. APR 25 '58	26. REGISTRAR'S SIGNATURE Karl Smith M.D.	

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

300  
1-57

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 *B. P. Kedwell* .....

Licensed Embalmer No. *3877* .....  
P. O. Address *7027 Gravois* .....

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.