

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-019679

STATE FILE NUMBER

318

1003

Registrar's No. 5360

MAY 28 1958

Registration District No.

Primary Registration District No.

300  
1-57

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis.</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Lukes Hospital</b>		Length of stay in hospital <b>0</b>	d. STREET ADDRESS (If outside, give location) <b>5830 Pershing, Ave.</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Elenore</b> Middle Last <b>Fish</b>			4. DATE OF DEATH Month <b>May</b> Day <b>20</b> Year <b>1958</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 23, 1893</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	9. AGE (In years last birthday) <b>65</b> IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Missouri.</b>
13a. FATHER'S NAME <b>Julius Grash</b>		13b. MOTHER'S MAIDEN NAME <b>Sophia Houser</b>	14. NAME OF HUSBAND OR WIFE <b>Roy Fish</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Roy A. Fish, 5830 Pershing, Ave.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Carcinoma of cervix &amp; widespread metastases</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
DUE TO (c) <b>metastases</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>171X</b>			
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.) <b>171X</b>	
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 <b>4/30/58</b> to <b>5/22/58</b> and last saw her/him alive on <b>5/29/58</b> Death occurred at <b>5 am</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>John B. Shoplugh M.D.</b>		22b. ADDRESS <b>3720 Washington</b>	22c. DATE SIGNED <b>5/21/58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE <b>5-23-58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Crematory</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>
24. FUNERAL DIRECTOR <b>Albert H. Hoppe</b>		ADDRESS <b>4700 Washington, Blvd.</b>	25. DATE RECD. BY LOCAL REG. <b>MAY 21 '58</b>
			26. REGISTRAR'S SIGNATURE <b>Carl Smith MD</b> m.B.

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.