

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

58-023795
 STATE FILE NUMBER

FILED JUN 27 1958

Registration District No. _____

318

Primary Registration District No. _____

1003

Registrar's No. _____

6325

300
 1-57

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 25 St. Louis City Hosp.		Length of stay in lb 12/7	d. STREET ADDRESS (If outside, give location) 2309 Division St. Apt. 403		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Geneva Stith			4. DATE OF DEATH Month Day Year 6 - 19 - 58		
5. SEX Female	6. COLOR OR RACE 3 Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 17, 1907		9. AGE (In years last birthday) 50
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Board of Education	11. BIRTHPLACE (City and state or country) Dekalb, Mississippi		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Charles Hampton		13b. MOTHER'S MAIDEN NAME Mary Crawford		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) no		16. SOCIAL SECURITY NO. 488-40-0736		17. INFORMANT Address June Stith (Son) 2309 Division St. Apr. 403	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Cystadenocarcinoma of Ovary DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 175.0					INTERVAL BETWEEN ONSET AND DEATH 1-2 yrs.
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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
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 6 - 16 - 58 to 6 - 19 - 58 and last saw her/him alive on 6 - 19 - 58 . Death occurred at 3:05 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Edwin H. Hane Rouns MD			22b. ADDRESS 1515 Lafayette		22c. DATE SIGNED 6 - 19 - 58
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 6/23-58	23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis Co. Mo
24. FUNERAL DIRECTOR Charles J. Gates		ADDRESS 4107 Finney Ave.		25. DATE RECD. BY LOCAL REG. JUN 23 '58	26. REGISTRAR'S SIGNATURE Carl Smith MD mjb

(Licensed Embalmer's Statement on Reverse Side)

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.

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 *Gayton Swan*

Licensed Embalmer No. *4580*

P. O. Address *4107 Junn*

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.