

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002916

STATE FILE NUMBER

2 1003

FILED FEB 16 1959

Registration District No. _____ Primary Registration District No. _____

Registrar No. _____

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1-57
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1. PLACE OF DEATH a. COUNTY		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>ST. LOUIS, MISSOURI</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Webster Groves</u> 4000 8
c. FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION) <u>BARNES HOSPITAL</u>		Length of stay in lb	d. STREET ADDRESS <u>2701 Leithia</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>ALBERT</u> Last <u>EWING</u>			4. DATE OF DEATH Month <u>JANUARY</u> Day <u>26</u> Year <u>1959</u>		
5. SEX <u>Male</u> 2	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>9-11-1914</u>	9. AGE (In years) IF UNDER 1 YEAR IF UNDER 24 HRS. <u>44</u> (last birthday) Months Days Hours Min.	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Business</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employee</u>	11. BIRTHPLACE (City and state or country) <u>Webster Groves Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Augusta Ewing</u>	13b. MOTHER'S MAIDEN NAME <u>Hallie Pierson</u>	14. NAME OF HUSBAND OR WIFE <u>Unknown</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>Hallie Ewing</u>	Address <u>331 Leithia</u>
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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 RECTUM WITH METASTASES TO LIVER</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c) <u>154X</u>	
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 <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 _____
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21. I attended the deceased from FEB. 25, 1956 to JAN. 26, 1959 and last saw her alive on JAN. 26, 1959
Death occurred at 5:25 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>G. D. Vermillion, M.D.</u> (Degree or title)	22b. ADDRESS <u>BARNES HOSPITAL</u>	22c. DATE SIGNED <u>1/26/59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>1-29-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Peters</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u>
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24. FUNERAL DIRECTOR <u>Lewis Funeral Home 22 Ecclid</u>	25. DATE RECD. BY LOCAL REG. <u>JAN 29 '59</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u> m. & B.
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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 *James A Carter*

Licensed Embalmer No. *4681*
P. O. Address *St. Louis*

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.