

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-003469

STATE FILE NUMBER

FILED JAN 26 1959

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

227

300
1-57
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
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>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u> Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>712 1/2 ADDRESS 4553 McMillian Ave.</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NANCY</u> Middle <u>IRENE</u> Last <u>SCAIFE</u>			4. DATE OF DEATH Month <u>JANUARY</u> Day <u>6</u> Year <u>1959</u>
5. SEX <u>F.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-19-1933</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse's Aide</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>No. Baptist Hospital</u>	11. BIRTHPLACE (City and state or country) <u>Rochester, Minnesota</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13a. FATHER'S NAME <u>Unknown</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>
14. NAME OF HUSBAND OR WIFE <u>John Scaife</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>473-32-4028</u>		17. INFORMANT Address <u>John Scaife - 4553 McMillian Ave</u>	
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>GENERALIZED PERITONITIS</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>PERFORATED APPENDIX</u> DUE TO (c) <u>550.1</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>24 HOURS</u> <u>UNKNOWN</u>
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. 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 <u>DEC. 27, 1958</u> to <u>JAN. 6, 1959</u> and last saw <u>her</u> alive on <u>JAN. 6, 1959</u> Death occurred at <u>4:10 P.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>J. C. Vermillion, M.D.</u>		22b. ADDRESS <u>BARNES HOSPITAL</u>	
22c. DATE SIGNED <u>1/7/59</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Jan. 9, 1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>National Cemetery Jefferson Bldg.</u>	23d. LOCATION (City, town, or county) (State) <u>Jefferson, Bks. Missouri</u>
24. FUNERAL DIRECTOR ADDRESS <u>Thomas Jackson, 2726 Dickson St.</u>		25. DATE RECD. BY LOCAL REG. <u>JAN 8 '59</u>	26. REGISTRAR'S SIGNATURE <u>J. Carl Smith, Jr.</u>

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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 *John K. Cunningham*

Licensed Embalmer No. *4476*
P. O. Address *2405 Marcus*

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.