THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-007779

STATE FILE NUMBER

FILED MAR 10 1959 Registration District No. ..... Primary Registration District No. ..... Registration No. 2 1988

1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY
b. CITY OR TOWN (If outside corporate limits, give TOWNSHIP only) St. Louis — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) Homer G. Phillips — Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 4517 Cottage — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: Preston	Middle:	Last: Whalen	4. DATE OF DEATH Month: 2	Day: 21 Year: 59
5. SEX: Male 2	6. COLOR OR RACE: Negro	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: 2-10-02	9. AGE (In years last birthday): 57 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country): Miss. 1	12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME: Selma Whalen	13b. MOTHER'S MAIDEN NAME: Caroline (Unknown)	14. NAME OF HUSBAND OR WIFE: Lenora Whalen		
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: Lenora Whalen-4517 A. Cottage	Address	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinomatosis

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Carcinoma of Thyroid

DUE TO (c) 194x

INTERVAL BETWEEN ONSET AND DEATH: undet.

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 ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

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 12-7-58, to 2-21-59 and last saw her/him alive on 2-21-59

Death occurred at 1:20 P m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: S. Maser (Degree or title) , M.D.	22b. ADDRESS: 2601 Whittier Street	22c. DATE SIGNED: 2-24-59	
23a. BURIAL, CREMATION, REMOVAL (Specify): Removal	23b. DATE: 2-28-59	23c. NAME OF CEMETERY OR CREMATORY: Washington Park Cem.	23d. LOCATION (City, town, or county) (State): Berkeley, Mo.
24. FUNERAL DIRECTOR: A.L. Beal Und.Co.-4303 Delmar	ADDRESS	25. DATE RECD. BY LOCAL REG.: FEB 25 '59	26. REGISTRAR'S SIGNATURE: Carl Smith. M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalme

by me, or by ....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed A. D. Richardson

Licensed Embalmer No. 2928

P. O. Address 2625

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failur 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.