

FILED MAR 27 1959

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-010907

STATE FILE NUMBER 2 2617

Registration District No. Primary Registration District No.

Registrar's No.

300  
-57

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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</b>		c. CITY OR TOWN <i>St. Louis</i>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>		d. STREET ADDRESS (If outside, give location) <b>1806 Laflin</b>	

3. NAME OF DECEASED (Type or print) First <b>Octavia</b> Middle <b>Ford</b> Last <b>Ford</b>			4. DATE OF DEATH Month <b>3</b> Day <b>11</b> Year <b>59</b>		
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>15 Feb. 1899</b>	9. AGE (In years last birthday) <b>60</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
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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>housewife</b>	11. BIRTHPLACE (City and state or country) <b>Arkansas</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
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13a. FATHER'S NAME <b>M. Mewis</b>	13b. MOTHER'S MAIDEN NAME <b>Unk.</b>	14. NAME OF HUSBAND OR WIFE <b>XXX</b>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give dates of service) <b>no</b>	16. SOCIAL SECURITY NO. <b>no</b>	17. INFORMANT Address <b>Samuel Lweis 1628a Burd</b>
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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) <b>SARCOMA OF UTERUS, &amp; METASTASES (PERITONEUM, LYMPH NODES, LUNG).</b>		INTERVAL BETWEEN ONSET AND DEATH <b>undet.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) <b>174X</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>HYDROPS OF CELL BLADDER, MALNUTRITION, DEHYDRATION</b>		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.)
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20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____
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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 <b>3-8-59</b> to <b>3-11-59</b> and last saw her <sup>her</sup> <sub>him</sub> alive on <b>3-11-59</b> Death occurred at <b>6:18</b> <b>A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE <i>S. A. Inaser</i> (Degree or title) <b>M.D.</b>	22b. ADDRESS <b>2601 Whittier Street</b>	22c. DATE SIGNED <b>3-12-59</b>

23a. BURIAL, CREMATION, REMOVAL <b>removal</b> (Specify)	23b. DATE <b>18 Mar. 59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Father Dickerson</b>	23d. LOCATION (City, town, or county) <b>St. Louis Co. Mo.</b> (State)
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24. FUNERAL DIRECTOR <b>Reliable Funeral Sys. 1389 N. Union</b> ADDRESS	25. DATE RECD. BY LOCAL REG. <b>MAR 14 59</b>	26. REGISTRAR'S SIGNATURE <i>Carol Smith</i> M.D.
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 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.