

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011414
STATE FILE NUMBER
Registrar 2 2424

REGISTRATION DISTRICT NO. _____ PRIMARY REGISTRATION DISTRICT NO. _____

MAR 30 1959

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</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Ladue</u> <u>4000</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>St. Lukes Hosp.</u>		Length of stay in 1b _____	d. STREET ADDRESS (If outside, give location) <u>23 Twin Springs Lane</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>JESSIE GRAFF STARMER</u>			4. DATE OF DEATH Month Day Year <u>March 7, 1959</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 23, 1886</u>
9. AGE (In years last birthday) <u>73</u>		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) <u>Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Forest City Mfg</u>	11. BIRTHPLACE (City and state or country) <u>Walnut Ridge, Ark</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Fritz E. Graff</u>	13b. MOTHER'S MAIDEN NAME <u>Susie Kirsch</u>
14. NAME OF HUSBAND OR WIFE <u>Warford Thomas Starmer</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. _____
17. INFORMANT <u>Mrs. Sue G. Goodall</u>		Address <u>23 Twin Springs Ln</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>Carcinoma, left breast with generalized metastases</u>			INTERVAL BETWEEN ONSET AND DEATH <u>30 months</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>170X</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? <u>2</u> YES <input type="checkbox"/> NO <input checked="" 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. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
20e. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____	20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____		
21. I attended the deceased from <u>Nov. 6, 1956</u> to <u>March 7, 1959</u> and last saw her alive on <u>March 7, 1959</u> Death occurred at _____ P. _____ m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) <u>[Signature]</u>	
22b. ADDRESS <u>337 W. Lockwood</u>		22c. DATE SIGNED <u>3-9-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>3/8/59</u>	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or country) (State) <u>Walnut Ridge, Ark</u>
24. FUNERAL DIRECTOR <u>Alexander & Sons, 6175 Delmar</u>		25. DATE RECD. BY LOCAL REG. <u>MAR 9 '59</u>	26. REGISTRAR'S SIGNATURE <u>[Signature]</u> <u>M. A. B.</u>

Health, Welfare, Public Service

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

ALL DISEASES IN PART I MUST BE CAUSALLY RELATED.

Locotor, coroner, etc. must use only standard nomenclature in terms of - No symptoms will be stated.

Medical Certification

Dr. James B. Jones
337 W. Lockwood Ave.
WO. 1-5656

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 *Jos. E. McCulloch*
Licensed Embalmer No. *2460*

P. O. Address *6175 Delmo*

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.