

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-016196

STATE FILE NUMBER

FILED APR 20 1959 Registration District No. 317 Primary Registration District No. 548 Registrar's No. 990

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>St. Louis</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>WEBSTER GROVES</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>WEBSTER GROVES</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>615 SELMA</b>		Length of stay in 1b <b>YRS</b>		d. STREET ADDRESS (If outside, give location) <b>615 SELMA</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>DOXIE ARGINT</b>				4. DATE OF DEATH Month Day Year <b>APRIL 10 1959</b>				
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</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>APRIL 17, 1902</b>		9. AGE (In years last birthday) <b>56</b>	10. FUNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <b>EUROPE</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13a. FATHER'S NAME <b>DENNIS BALAMACI</b>			13b. MOTHER'S MAIDEN NAME <b>TINA KARELIS</b>			14. NAME OF HUSBAND OR WIFE <b>DECEASED</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>NICK ARGINT 615 SELMA W.G., MO.</b>				
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>Renovated Carcinomatous</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <b>Primary in right Breast</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>170X</b>						INTERVAL BETWEEN ONSET AND DEATH		
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 WORK <input type="checkbox"/> 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 <b>Sept 13, 1958</b> to <b>April 10<sup>th</sup></b> and last saw <sup>her</sup> <sub>him</sub> alive on <b>April 9 - 1959</b> . Death occurred at <b>6:30A</b> m on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <b>George A. Carroll M.D.</b>				22b. ADDRESS <b>607 N. Grand</b>			22c. DATE SIGNED <b>4/10/59</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		23b. DATE <b>4/13/1959</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. MATTHEW'S CEM.</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>J L ZIEGENHEIN &amp; SONS 7027 GRAVOIS</b>				25. DATE RECD. BY LOCAL REG. <b>4-11-59</b>		26. REGISTRAR'S SIGNATURE <b>John C. Murphy M.D.</b>		

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 *Donald Benz* .....

Licensed Embalmer No. *9963* .....

P. O. Address *St. Louis, 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.