

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 4 1959

59-026605

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STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY _____ c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 1126 Maple Place Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Rhoda Middle Bell Last Esters			4. DATE OF DEATH Month 7 Day 23 Year 59				
5. SEX FE MALE	6. COLOR OR RACE COL.	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/24/07	9. AGE (last birthday) 51	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY DOMESTICS		11. BIRTHPLACE (City and state or country) PIKEBLUFF ARKANSAS		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME JAMES ESTERS			13b. MOTHER'S MAIDEN NAME SERENA GRANT			14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO NONE		16. SOCIAL SECURITY NO. 500-18-8827		17. INFORMANT Bessie Esters Address 1126 MAPLE PLACE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LUNG Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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) CEREBRAL TUBERCULOSIS				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? 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 _____ Month, Day, Year _____ a.m. _____ p.m. _____							
20d. INJURY OCCURRED WHILE AT WORK <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 6-25-59 , to _____, and last saw her her alive on 7-23-59 Death occurred at 5:35 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
21a. SIGNATURE (Degree or title) Paul W. Lamm , M. D.				22b. ADDRESS 2601 N. Whittier St.		22c. DATE SIGNED 7-23-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 7/28/59		23c. NAME OF CEMETERY OR CREMATORY WASHINGTON PARK CEMETERY		23d. LOCATION (City, town, or county) ST. LOUIS. (State) MISSOURI	
24. FUNERAL DIRECTOR ADDRESS John H. Houston 2812 THOMAS ST.			25. DATE RECD. BY LOCAL REG. JUL 25 '59		26. REGISTRAR'S SIGNATURE Paul Smith. M.D.		

DOCUMENT

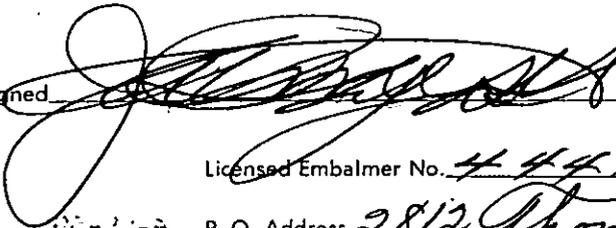
MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed 
Licensed Embalmer No. 444
P. O. Address 2812 Thom

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.