

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS AUG 5 1959

59-026700

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 6946** STATE FILE NUMBER

DED

| | | | | | | | |
|---|--|---|--|--|---|---|-------|
| 1. PLACE OF DEATH a. COUNTY | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri | | Length of stay in lb 56 yrs. | | c. CITY OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Barnes Hospital | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 5556 Easton Ave. | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last MARGARET MARY GREGORY | | | 4. DATE OF DEATH Month Day Year JULY 25, 1959 | | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 9/6/1902 | 9. AGE (last birthday) 56 | IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (City and state or country) St. Louis, Mo. | | 12. CITIZEN OF WHAT COUNTRY U.S. | |
| 13a. FATHER'S NAME John F. Foristal | | | 13b. MOTHER'S MAIDEN NAME Catherine Blethroad | | 14. NAME OF HUSBAND OR WIFE Joseph | | |
| 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 Address Ann Quirk 5556 Easton Ave. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Left Breast | | | | | | INTERVAL BETWEEN ONSET AND DEATH 8 months | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | | | | | 170x | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | | 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 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.) | | | |
| 20c. TIME OF INJURY Hour a.m. p.m. | | Month, Day, Year | | | | | |
| 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 5/31/59 to 7/25/59 and last saw her ^{her} _{him} alive on 7/25/59 Death occurred at 6:10 a.m. m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE <i>C. O. McMillian M.D.</i> (Degree or title) | | | | 22b. ADDRESS Barnes Hospital | | 22c. DATE SIGNED 7/26/59 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 7/28/1959 | 23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery | | 23d. LOCATION (City, town, or county) (State) St. Louis, Missouri | | |
| 24. FUNERAL DIRECTOR Morrell Mortuary, 3710 North Grand | | | | ADDRESS | 25. DATE RECD. BY LOCAL REG. JUL 27 '59 | 26. REGISTRAR'S SIGNATURE <i>Roald Smith. M.D.</i> | |

(Licensed Embalmer's Statement on Reverse Side)

S.P.

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 Lorou E. Percival

Licensed Embalmer No. 4094

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.