

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
**FILED VS OCT 8 1959**

**59-034229**

**2 8936**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

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>		Length of stay in 1b	c. CITY OR TOWN <b>St. Louis</b>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>3226 Lawton</b>
		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Joe</b> Middle <b>NMN</b> Last <b>Rice</b>			4. DATE OF DEATH Month <b>9</b> Day <b>24</b> Year <b>59</b>			
--	--	--	---	--	--	--

5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9-4-1908</b>	9. AGE (last birthday) <b>51</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>20</b>	IF UNDER 24 HR Hours <b></b> Min. <b></b>
--------------------	-------------------------------	---	----------------------------------	----------------------------------	---	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (City and state or country) <b>Mississippi</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
---	--	--	--	--	--	--	--

13a. FATHER'S NAME <b>Joe Rice</b>		13b. MOTHER'S MAIDEN NAME <b>Josephine Thurman</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>	
---------------------------------------	--	---	--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>?</b>	17. INFORMANT <b>Evelyn Knox</b> Address <b>761 Euclid Avenue</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>Carcinoma of Pancrease with Metastasis to Liver</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>157x</b>			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Hepatic Coma</b>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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 _____ 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 **8-30-59** to **9-24-59** and last saw <sup>Mr</sup>him alive on **9-24-59**  
 Death occurred at **4:10** a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>[Signature]</i> (Degree or title)		22b. ADDRESS <b>2601 N. Whittier St.</b>		22c. DATE SIGNED <b>9-24-59</b>	
---	--	---	--	------------------------------------	--

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>9-29-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenwood</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Missouri</b>	
---	-----------------------------	--	--	--	--

24. FUNERAL DIRECTOR <b>Ellis Funeral Home</b> ADDRESS <b>2820 Stoddard St.</b>		25. DATE RECD. BY LOCAL REG. <b>SEP 28 59</b>	26. REGISTRAR'S SIGNATURE <i>[Signature]</i> <b>M.D.</b>		
--	--	--	---	--	--

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 me  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Fulton G. Culkin

Licensed Embalmer No. 4198  
P. O. Address St Louis,

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.