

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-008171

FILED VS MAR 11 1960

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 2390**

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		Length of stay in 1b	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 ST. LOUIS CITY HOSP. #1		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5475 Vernon Ave		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) DOROTHY ENYARD			4. DATE OF DEATH Month FEB. Day 27 Year 1960		
5. SEX Female	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1-23-1918	9. AGE (last birthday) 46	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Prof. Family		11. BIRTHPLACE (City and state or country) St. Louis, MO.	12. CITIZEN OF WHAT COUNTRY U.S.A.
13a. FATHER'S NAME Tom Frie		13b. MOTHER'S MAIDEN NAME MARY Calloway		14. NAME OF HUSBAND OR WIFE Alfred ENYARD	
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. 489167078		17. INFORMANT Alfred Enyard Address 5475 Vernon Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) CARCINOMATOSIS					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					
DUE TO (b) ADENO CARCINOMA OF BREAST BILATERAL					
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 _____ Month, Day, Year _____ s.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 FEB. 18, 1960 to FEB. 27, 1960 and last saw her ^{him} alive on FEB. 27, 1960 Death occurred at 12:15 am on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE John Allen Beurell M.D.			22b. ADDRESS 1515 LAFAYETTE AVE.		22c. DATE SIGNED 2/27/60
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 2-3-60	23c. NAME OF CEMETERY OR CREMATOR Washington Park		23d. LOCATION (City, town, or county) (State) St. Louis County MO.	
24. FUNERAL DIRECTOR J. McCendon		ADDRESS 4535 Washington	25. DATE RECD. BY LOCAL REG. MAR 1 1960	26. REGISTRAR'S SIGNATURE Carl 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. 5077
P. O. Address 4535 WASH

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.