

UNRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-013065

FILED VS APR 4 1960

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 2995** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MISSOURI b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		Length of stay in 1b 6 WEEKS	c. CITY OR TOWN ROCK HILL Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 823 ROCK HILL ROAD Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First ANNA Middle E. Last PERKINS			4. DATE OF DEATH Month MARCH Day 13 Year 1960		
5. SEX FEMALE	6. COLOR OR RACE CAUCASIAN	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 4/19/1914	9. AGE (last birthday) 45	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 AT HOME	11. BIRTHPLACE (City and state or country) ST. LOUIS, MISSOURI	12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME ROBERT E. WELSH		13b. MOTHER'S MAIDEN NAME MARY GALLAGHER		14. NAME OF HUSBAND OR WIFE VIRGIL H. PERKINS	

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. NONE	17. INFORMANT Address VIRGIL H. PERKINS, 823 ROCK HILL RD.
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Melanotic Carcinoma		INTERVAL BETWEEN ONSET AND DEATH 2 yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Adenocarcinoma right breast	2 yrs
	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
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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.)
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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
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21. I attended the deceased from 3/1/60 to 3/13/60 and last saw her live on 3/13/60 Death occurred at 1:38 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Edward W. Czuchra M.D.	22b. ADDRESS 3701 Brandel Sq	22c. DATE SIGNED 3/14/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 3/16/1960	23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY	23d. LOCATION (City, town, or county) W. FLORISSANT RD. ST. LOUIS
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24. FUNERAL DIRECTOR ADDRESS HOFFMEISTER COLONIAL MORTUARY 6464 CHIPPEWA STREET, ST. LOUIS, MO.	25. DATE RECD. BY LOCAL REG. MAR 14 1960	26. REGISTRAR'S SIGNATURE Carl Smith, M.D.
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(Licensed Embalmer's Statement on Reverse Side)

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 James C. Hoffner

Licensed Embalmer No. 3871

P. O. Address 7814 S. D.

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.