

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 14 1960

=60-036649

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9710 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS, MISSOURI</u>			Length of stay in 1b <u>25-yrs.</u>	c. CITY OR TOWN <u>Afton</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>BARNES HOSPITAL</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <u>9928 Reavis Road</u>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>PAULINE</u> Middle <u>T.</u> Last <u>TILFORD</u>			4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>5</u> Year <u>1960</u>					
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>10/9/1900</u>	9. AGE (last birthday) <u>59</u>		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) <u>House Mother, no school of the Blind</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>John Riley</u>			13b. MOTHER'S MAIDEN NAME <u>Christina Fields</u>			14. NAME OF HUSBAND OR WIFE <u>Edgar L. Tilford</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown); (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>498-44-8657</u>		17. INFORMANT Address <u>Mrs. Pauline R. Schwalke, 9928 Reavis Road</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF ESOPHAGUS</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 YEARS</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b)		DUE TO (c) <u>150X</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)						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 <u> </u> a.m. <u> </u> p.m. Month, Day, Year <u> </u>	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 <u>JULY 5, 1945</u> to <u>OCT. 5, 1960</u> and last saw her alive on <u>OCT. 5, 1960</u> Death occurred at <u>2:55 P.M.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>E. O. Vermillion, M.D.</u> (Degree or title)				22b. ADDRESS <u>BARNES HOSPITAL</u>		22c. DATE SIGNED <u>10/5/60</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>10/7/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		23d. LOCATION (City, town, or county) <u>Martinsville, Indiana</u>		(State)		
24. FUNERAL DIRECTOR <u>Wm. J. Donnell</u>			ADDRESS <u>3840 Lindell Blvd.</u>	25. DATE RECD. BY LOCAL REG. <u>OCT 6 1960</u>	26. REGISTRAR'S SIGNATURE <u>Earl Smith, M.D.</u>			

DOCUMENT

MEDICAL CERTIFICATION

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 Francis Williams

Licensed Embalmer No. 356

P. O. Address 38407

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.