# MISSOURI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

AMENDED

Registration District No. 818 Primary Registration District No. 1003 Registrar's No. 1845 STATE FILE NUMBER 61-007017

FILED VS MAR 7 1961

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis, Missouri — Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Firman Desloge Hospital — Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY
c. CITY OR TOWN: St. Louis, Missouri — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 3711 A. Windsor — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Effie — Middle: — Last: West
4. DATE OF DEATH: Month: February — Day: 20, — Year: 1961
5. SEX: Female
6. COLOR OR RACE: Negro
7. Married ☐ Never Married ☐ Widowed ☒ Divorced ☐
8. DATE OF BIRTH: 4/16/1898
9. AGE (last birthday): 62 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HR: 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: None
11. BIRTHPLACE (City and state or country): Kansas City, Missouri
12. CITIZEN OF WHAT COUNTRY: U. S. A.
13a. FATHER'S NAME: Henry Ford
13b. MOTHER'S MAIDEN NAME: Mary Brooks
14. NAME OF HUSBAND OR WIFE: Deceased
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ———
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Frank G. West — Address: 3725 J. Street Washington D.C.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Abdominal Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 3 mo
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Primary Site Probably
DUE TO (c): Ovarian 175.0

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. ☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 2-10-61, to 2-20-61 and last saw her alive on 2-20-61
Death occurred at 7 00 pm. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Martin G. Austin M.D.
22b. ADDRESS: 634 N Grand
22c. DATE SIGNED: 2-24-61

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 2/24/61
23c. NAME OF CEMETERY OR CREMATORY: St. Peters Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis County, Missouri

24. FUNERAL DIRECTOR: E. L. Koonce — ADDRESS: 1221 North Grand
25. DATE RECD. BY LOCAL REG.: FEB 23 1961
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

| ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED |
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BY AFFIDAVIT OF DOCUMENT

## 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_____ Signed Melvin Blackburn

Signature of Student Embalmer

Licensed Embalmer No. 3962

P. O. Address 1221 N Grand

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.