# MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

61-010785
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2302

AMENDED

FILED MAR 23 1961

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS — Length of stay in 1b: 13 YRS.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: 2743A ANN AVE. — 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 — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 2743 A ANN AVE — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First EVA Middle DELPHINE Last FLOWERS
4. DATE OF DEATH: Month MARCH Day 7 Year 1961
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. Married ☐ Never Married ☐ Widowed ☐ Divorced ☒
8. DATE OF BIRTH: JAN. 2, 1875
9. AGE (last birthday): 86 — 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: —
11. BIRTHPLACE (City and state or country): FRANKLIN Co. MO.
12. CITIZEN OF WHAT COUNTRY: U.S.A.
13a. FATHER'S NAME: CONRAD DILL
13b. MOTHER'S MAIDEN NAME: MARGARET ANGERER
14. NAME OF HUSBAND OR WIFE: —
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.: NONE
17. INFORMANT: MAYBELLE FLOWERS Address: ST. LOUIS, MO.

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): Cancer of Stomach — INTERVAL BETWEEN ONSET AND DEATH: 4 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 151X

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 Jan. 5-1961 to Mar 7-1961 and last saw her/him alive on Mar 7-1961
Death occurred at 2:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Ralph Berg (Degree or title) MD
22b. ADDRESS: 3203 S. Grand
22c. DATE SIGNED: 3/7/61

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: MARCH 9, 1961
23c. NAME OF CEMETERY OR CREMATORY: I.O.O.F. CEMETERY
23d. LOCATION (City, town, or county) (State): SULLIVAN MO
24. FUNERAL DIRECTOR: H.M. EATON ADDRESS: SULLIVAN MO.
25. DATE RECD. BY LOCAL REG.: MAR 8 1961
26. REGISTRAR'S SIGNATURE: Noal Smith, M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

| ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED |
|---|---|---|---|
| | | | |

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 _____
Signature of Student Embalmer

Signed Harrison M. Eaton

Licensed Embalmer No. 4192

P. O. Address Sullivan, Mo

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.