

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-008344

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318**

318

Primary Registration District No. **1003**

1003

Registrar's No. **2297**

2297

STATE FILE NUMBER

DO NOT WRITE ON THIS STUD

AMENDED

FILED MAR 8 1963

VS 300
Rev. 4/59

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STATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

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) St. Louis		c. CITY OR TOWN St. Louis	
Length of stay in 1b 22 yrs		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION D.O.A. Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 3846a Sullivan Ave.	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JOANNA BOLIN		4. DATE OF DEATH Month Day Year Feb. 26 1963	
5. SEX Female	6. COLOR OR RACE Col	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3-13-1910
9. AGE (last birthday) 52		IF UNDER 1 YEAR Months 11 Days 13 Hours Min. 	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) Charleston, Miss.		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13a. FATHER'S NAME Robert Smith		13b. MOTHER'S MAIDEN NAME Annie Epps	
14. NAME OF HUSBAND OR WIFE Joe Bolin			
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. 5	
17. INFORMANT Joe Bolin		Address 3846a Sullivan Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for each line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis DUE TO (b) Epidermoid carcinoma of Cervix DUE TO (c) 171X Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
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 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 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	
21. I attended the deceased from 1959 to present and last saw her/him alive on Feb 15, 1963 Death occurred at 10:00 PM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Ray D. Woff, M.D.		22b. ADDRESS 216 S. Kingshighway	
22c. DATE SIGNED 2/27/63			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE March 4, 1963	23c. NAME OF CEMETERY OR CREMATORY Washington Park	
23d. LOCATION (City, town, or county) St. Louis County Missouri		23e. STATE	
24. FUNERAL DIRECTOR JAS. H. RANDLE & SON		25. DATE RECD. BY LOCAL REG. FEB 28 1963	
ADDRESS 3133 Bell Ave.		26. REGISTRAR'S SIGNATURE Joan Smith, M.D.	

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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 *Ether K. Harner*

Licensed Embalmer No. *4458*

P. O. Address *4181 Washington*

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.