

Registration District No. **7911**Primary Registration District No. **1003**Registrar's No. **9399**

1. PLACE OF DEATH:

(a) County _____

(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
BARNES HOSPITAL
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME **EANY MAC-YELL**8. (b) If veteran, name war **No.** 3. (c) Social Security No. **None**4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widowed**6. (b) Name of husband or wife **John A.** 6. (c) Age of husband or wife if alive _____ years7. Birth date of deceased **April 9 1980**
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
60 **7** **5** _____ hr. _____ min.9. Birthplace **Olney Illinois**
(City, town, or county) (State or foreign country)10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **Charles F. Morehouse**13. Birthplace **Olney Illinois**
(City, town, or county) (State or foreign country)14. Maiden name **Mary Stephenson**15. Birthplace **Bloomington Illinois**
(City, town, or county) (State or foreign country)16. (a) Informant's own signature **Aden K. Morehouse**(b) Address **Portland, Oregon.**17. (a) **Removal** (b) Date thereof **11/15/40**
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation **Olney, Ill.**18. (a) Signature of funeral director **Albert H. Hoppe**(b) Address **4700 Washington Ave.**19. (a) **NOV 15 1940** (b) *[Signature]*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **ILLINOIS** (b) County _____

(c) City or town **OLNEY** **NR**
(If outside city or town limits, write "RURAL")

(d) Street No. **429 RICHLAND**
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **NOVEMBER** day **14**
year **1940** hour _____ minute **00** P. M.21. I hereby certify that I attended the deceased from
SEPTEMBER 20, 1940, to **NOVEMBER 14**, 1940;
that I last saw her alive on **NOVEMBER 14**, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

CachexiaDue to **Carcinomatous**Due to **Serous papillary cystadenocarcinoma of ovary**

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: **Serous papillary cystadenocarcinoma of ovary with metastases**

Of operations _____

Of autopsy **None obtained**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)

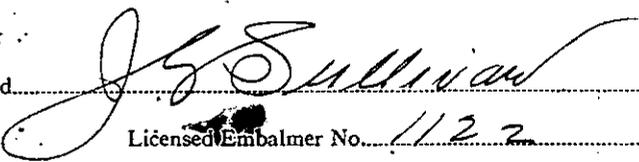
(e) Means of injury _____

23. Signature **John N. Mayer Jr.** (M. D. or other) _____Address **BARNES HOSPITAL** Date signed **11/14/40**

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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed .....
Licensed Embalmer No. 1122.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.