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MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **34527**
Registrar's No. **8817**

FILED OCT 23 1948 **318**
Registration District No. **318**

Primary Registration District No. **1003**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
St. Johns Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Elizabeth Nufer

3. (b) If veteran, name war None

3. (c) Social Security No. 500-24-2606

4. Sex Female / 5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Frederick

6. (c) Age of husband or wife if alive Dec'd years

7. Birth date of deceased April 7 1877
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

71 5 2 hr. _____ min.

9. Birthplace Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business Self

12. Name Robert J. Fitzpatrick

13. Birthplace Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Annie Hackman

15. Birthplace Pa.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Vida Hoffman

(b) Address 3729 N. Euclid

17. (a) Burial (b) Date thereof 10/12/48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mathews Cem.

18. (a) Signature of funeral director PROVOST UND. CO.

(b) Address 3710 N. Grand Bldg.

19. (a) Oct 11 1948 (b) J. B. Pasater
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 4109 Gano Ave.
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 9
year 1948 hour 9 minute 30 P. M.

21. I hereby certify that I attended the deceased from Monday
1948 to Oct 9 1948
that I last saw her alive on Oct 9 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of L. ovary
and metastasis to entire
Due to past infections of throat

Due to _____

Other conditions H9
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

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 J. B. Pasater (M. D. or other) MD

Address 41439 N. ... Date signed Oct 11 48

Handwritten notes and initials in the top right corner.

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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 *Albert Mayfield*

Licensed Embalmer No. *3077*

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, fact should be so stated above.