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FILED MAR 8 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6954

State File No. 00252

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. _____

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jennings
c. LENGTH OF STAY (In this place) 1
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5461 Hodiamont Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo.
b. COUNTY St. Louis 76
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jennings 0 0
d. STREET ADDRESS (If rural, give location) 5461 Hodiamont Ave 0

3. NAME OF DECEASED (Type or Print) a. (First) CLARA b. (Middle) A. c. (Last) AUDRAIN

4. DATE OF DEATH (Month) FEB (Day) 1 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH May 1, 1893
9. AGE (In years last birthday) 55 — If under 1 year: Months 9, Days 0 — If under 24 hrs.: 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 (State or foreign country) St. Charles, Mo. 0
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Wm. Buerges
13b. MOTHER'S MAIDEN NAME Francis Scharer
14. NAME OF HUSBAND OR WIFE William Audrain

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME Wm. Audrain ADDRESS 5461 Hodiamont Ave

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Adeno-Ca. Rt Ovary — 2 1/2 yrs
DUE TO (c) 49a

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
175A

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) —
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 10 1948 to Feb 1, 1949, *that I last saw the deceased alive on* 1-1, 1949, *and that death occurred at* 450 *m, from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Leo J. Reilly, M.D.
23b. ADDRESS 8105 Page Blvd
23c. DATE SIGNED 2-2-49

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Feb 4 1949
24c. NAME OF CEMETERY OR CREMATORY Calvary
24d. LOCATION (City, town, or county) St. Louis (State) Mo.

DATE REC'D BY LOCAL REG. 2/2/49
REGISTRAR'S SIGNATURE Thurich V. Lininger, M.D.
25. FUNERAL DIRECTOR'S SIGNATURE Mark Tiemon ADDRESS 6100 W. Florissant Ave.

(Licensed Embalmer's Statement on Reverse Side)

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

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.

Signed Mark Tillman

Signed.....
Student Embalmer

Licensed Embalmer No. 4174

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.