

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2167 Registrar's No.

No. 300
10.48

FILED MAR 19 1949

BIRTH NO. #88215 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Louis City Hospital #1.		d. STREET ADDRESS (If rural, give location) 5458 Gravois	
3. NAME OF DECEASED (Type or Print) a. (First) LENA b. (Middle) MACKLIN c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) March 7th, 1949
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Apr. 9, 1859
9. AGE (In years last birthday) 89		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home		10b. KIND OF BUSINESS OR INDUSTRY ---	11. BIRTHPLACE (State or foreign country) Portland, Kentucky
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Unknown	
13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Philip	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT'S SIGNATURE OR NAME Sophia Schafler--		ADDRESS 5458 Gravois Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of the Breast - Generalized metastasis		INTERVAL BETWEEN ONSET AND DEATH 3	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES DUE TO (b) DUE TO (c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		50	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 1/10X	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1/10/49, 19__, to 3/7/49, 19__, that I last saw the deceased alive on 3/7/49, 19__, and that death occurred at 1:30AM., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) W.M. Turner, M.D.		23b. ADDRESS 1515 Lafayette Ave.,	
23c. DATE SIGNED 4/7/49		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 3/9/49		24c. NAME OF CEMETERY OR CREMATORY St. Matthews Cemetery	
24d. LOCATION (City, town, or county) (State) St. Louis, Missouri		25. FUNERAL DIRECTOR'S SIGNATURE Wacker-Heldt	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE MAR. 8 REG. 1949 J. B. Sauters		ADDRESS 3634 Gravois	

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 _____

Delid J. Krupic

Signed _____
Student Embalmer

Licensed Embalmer No. _____

3497

P. O. Address _____

3634 Garrai

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.