

FILED JUN 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21381

State File No.

318

1003

5183

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) <u>Life</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		17	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Peoples Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>4236 Enright Avenue</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Ira</u> b. (Middle) <u>Mae</u> c. (Last) <u>McFadden</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>6/11/49</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>5/26/10</u>	9. AGE (In years last birthday) <u>39</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (State or foreign country) <u>St. Louis, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>John B. Dickerson</u>		13b. MOTHER'S MAIDEN NAME <u>Dovie B. Baker</u>		14. NAME OF HUSBAND OR WIFE <u>Orzie E. McFadden</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW II</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Thelma Dickerson, 4236 Enright Ave.</u>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>PROBABLE CARCINOMA OF LUNGS</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>BILATERAL DERMOID CYSTS OF OVARIES (REMOVED IN NOV. 1948).</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>RECTO-ABDOMINAL FISTULA GENERAL DEBILITATION</u>				INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u> <u>8 months</u> <u>6 months</u>	
19a. DATE OF OPERATION <u>11-4-48</u>		19b. MAJOR FINDINGS OF OPERATION <u>LARGE BILATERAL DERMOID CYSTS OF BOTH OVARIES</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>NONE</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>417</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>162X</u>			
22. I hereby certify that I attended the deceased from <u>Oct. 7</u> , 1948, to <u>June 11</u> , 1949, that I last saw the deceased alive on <u>June 11</u> , 1949, and that death occurred at <u>12:49 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>L. Elizabeth Courtney, M.D.</u>				23b. ADDRESS <u>4602a Page Blvd.</u>		23c. DATE SIGNED <u>6-12-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>6-15-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Missouri</u>	
DATE REC'D BY LOCAL REG. <u>JUN 15 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Lasater</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Chas. J. Gates, 4107 Finney Avenue</u>			

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

John K. Cunningham

Signed.....
Student Embalmer

Licensed Embalmer No. 4472

P. O. Address 4107 Finney Avenue

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.