

FILED AUG 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28149

State File No.

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. <u>72215</u>			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis Co.</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Overland</u>		96			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. John Hospital</u>				4. STREET ADDRESS <u>9500 Echo Lane,</u>		13 1			
3. NAME OF DECEASED (Type or Print) a. (First) <u>MARY</u>			b. (Middle) <u>A.</u>			c. (Last) <u>HENKE.</u>			
4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 22, 1949.</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>			
8. DATE OF BIRTH <u>April 4, 1895.</u>		9. AGE (In years last birthday) <u>54</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>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13a. FATHER'S NAME <u>Pratt M. Woolford</u>			13b. MOTHER'S MAIDEN NAME <u>Narsisa Palmer</u>			14. NAME OF HUSBAND OR WIFE <u>Walter Henke Husband</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Walter Henke, 9500 Echo Lane, Overland</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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bilateral Carcinoma of Breast with Metastasis to lungs.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u>	
				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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.					
19a. DATE OF OPERATION <u>10-22-43 - ION</u> <u>7-3-45</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of Breast</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) <u>50</u>					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>170X</u>					
22. I hereby certify that I attended the deceased from <u>8-9</u> , 19 <u>49</u> , to <u>8-22</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>8-21</u> , 19 <u>49</u> , and that death occurred <u>6:10 A.M.</u> from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>H. L. Joubert</u> M.D.				23b. ADDRESS <u>634 N. Grand St. Louis Mo.</u>		23c. DATE SIGNED <u>8-22-49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Aug. 24, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Hiram Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>			
DATE REC'D BY LOCAL REG. <u>8116 22 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Farster</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Jos. W. Clark, 1125 Hodiamont Ave.</u>					

(Licensed Embalmer's Statement on Reverse Side)

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

Dr. W. L. Tomlinson,
4520 Forest Park Blvd.,
Rd. 75930, Res.
Office Mo. Ther. Bldg.,
NE. 5234 1.30 P.M.

Emb. separate Cert filed

AUG

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.

Student
Student Embalmer

Signed.....

Licensed Embalmer No. 2663

P. O. Address 1125 Hodiament Ave

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.