

FILED OCT 19 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35944

Registrar's No. 4118

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 4467

REGISTRAR'S NO. 4118

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>ST. LOUIS</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>VALLEY PARK.</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>VALLEY PARK.</u>	
c. LENGTH OF STAY (in this place) <u>20 YRS.</u>		d. STREET ADDRESS (If rural, give location) <u>FRISCO SECTION HOUSE</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>FRISCO SECTION HOUSE</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>FRANCES</u> b. (Middle) <u>L.</u> c. (Last) <u>SMITH</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>OCT-10-1949</u>		
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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>AUG-7-1900</u>	9. AGE (In years last day) <u>49</u>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
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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 <u>OWN HOME</u>	11. BIRTHPLACE (State or foreign country) <u>MARYS CO - MO</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>EDWARD CRUM</u>	13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE <u>LESTER SMITH</u>
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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. <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>LESTER SMITH. VALLEY PARK, MO.</u>	ADDRESS
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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		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma</u>		<u>18 mos</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>General organic metastases</u> DUE TO (c) <u>of vital organs of abdomen</u>		<u>12 mos.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death <u>Malnutritional toxemia</u>		<u>4 mos.</u>	

19a. DATE OF OPERATION <u>Feb. 1949</u>	19b. MAJOR FINDINGS OF OPERATION <u>Primary cancer of ovary with general abdominal metastases</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <input checked="" type="checkbox"/>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) <u>175X</u> (COUNTY) (STATE)
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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?
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22. I hereby certify that I attended the deceased from 8-6-49, 1949, to 10-10-49, 1949, that I last saw the deceased alive on 9-6-49, 1949, and that death occurred at 10:11 A.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>C. C. Bennett, M.D., D.</u>	23b. ADDRESS <u>Valley Park, MO</u>	23c. DATE SIGNED <u>10/10/49</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>OCT-12-49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>RADER CEM.</u>	24d. LOCATION (City, town, or county) (State) <u>MARYS CO - MO.</u>
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>OCT 11 1949</u>	REGISTRAR'S SIGNATURE <u>Herbert A. Romke, M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>SCHROEDER FUNERAL HOME - BALLYWIN, MO.</u>	ADDRESS
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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 _____

working under my personal supervision.

Student Embalmer No. _____

Student _____
Student Embalmer

Signed *Geo. Schrader* _____

Licensed Embalmer No. *3066* _____

P. O. Address *Balwin, Mo.* _____

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.