

FILED NOV 25 1949

#103387

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

318

1003

State File No. 38661
9872

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 Missouri b. COUNTY K-6	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.		d. STREET ADDRESS (If rural, give location) 11- 1820 Taylor Ave.	

3. NAME OF DECEASED (Type or Print)	a. (First) WANDA	b. (Middle)	c. (Last) DONOHUE	4. DATE OF DEATH (Month) (Day) (Year) November 14th, 1949
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 30, 1890	9. AGE (In years last birthday) 59	IF UNDER 1 YEAR Months Days	IF UNDER 1 HR. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Finisher	10b. KIND OF BUSINESS OR INDUSTRY Natl. Tailoring	11. BIRTHPLACE (State or foreign country) St. Louis	12. CITIZEN OF WHAT COUNTRY? D
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13a. FATHER'S NAME Albert Urbaniak	13b. MOTHER'S MAIDEN NAME Caroline Terton	14. NAME OF HUSBAND OR WIFE Walter
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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)	16. SOCIAL SECURITY NO. 494 099 599	17. INFORMANT'S SIGNATURE OR NAME Mary Sophie Weidinger	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, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Adenocarcinoma of Right Breast with widespread metastasis</i>		19. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH 7 mos +
	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	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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) 30
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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? 170X
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22. I hereby certify that I attended the deceased from 9/7/49, 19, to 11/14/49, 19, that I last saw the deceased alive on 11/14/49, 19, and that death occurred at 10:45am, from the causes and on the date stated above.

23a. SIGNATURE Walker M. Turner, M.D.	(Degree or title)	23b. ADDRESS 1515 Lafayette Ave.,	23c. DATE SIGNED 11/14/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 11/17/49	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis Mo
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE NOV 16 1949 J. B. Basater	25. FUNERAL DIRECTOR'S SIGNATURE St. Louis Funeral Home 2205 St. Louis	ADDRESS
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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.

Student
Student Embalmer

Signed.....

Edmund R. Bodwell

Licensed Embalmer No.

4877

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.