

FILED MAY 5 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14749**
Registrar's No. **3769**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE	
b. CITY (If outside corporate limits, write RURAL and give township)		b. COUNTY	
c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township)	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS	

County: **St. Louis** State: **MO**
 City: **St. Louis** Township: **219**
 Hospital: **Homer G Phillips Hospital** Street: **3002 Lawton**

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH			
a. (First)	b. (Middle)	c. (Last)	(Month)	(Day)	(Year)	
Sarah Lucas			April 22 1950			
5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.
Female	Col.	Widow	Aug 9, 1873	77	Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Home Work			St. Louis MO			

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
Unknown	Unknown	
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.	17. INFORMANT'S SIGNATURE OR NAME
		Lucille Hyde
		ADDRESS
		3002 Lawton

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)			Undet.
	Carcinoma of Umbilicus with metastases			
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.		Intestinal Obstruction		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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)
		191X
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?

22. I hereby certify that I attended the deceased from **4-12**, 19**50**, to **4-22**, 19**50**, that I last saw the deceased alive on **4-22**, 19**50**, and that death occurred at **10:50a m.**, from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Montague Lawrence	D.	2601 N Whittier St	4-24-50
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	April 26, 50	Oak Dale	St. Louis MO
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
APR 25 1950	J. B. Lasater	F. G. Allen	4214 Delmar

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed F. G. Moore

Signed.....
Student Embalmer

Licensed Embalmer No. 2963

P. O. Address 4214 Delmar

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.