

FILED MAY 27 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 17877
Registrar's No. 83

0923
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BIRTH NO. _____ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 3058

1. PLACE OF DEATH a. COUNTY St Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St Charles	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Rt # 3 ST. CHARLES		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Rt 3	
c. LENGTH OF STAY (in this place) 40 yrs		d. STREET ADDRESS (If rural, give location) Rural Rt # 3	
d. FULL NAME OF HOSPITAL OR INSTITUTION St Joseph Hospital			
3. NAME OF DECEASED a. (First) Edna b. (Middle) Ott c. (Last) Ott			4. DATE OF DEATH (Month) (Day) (Year) May 17 1950
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 31 1904
9. AGE (In years last birthday) 45		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) House keeper		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) 0
12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME Fred Blohm		13b. MOTHER'S MAIDEN NAME Mary Feldmann	14. NAME OF HUSBAND OR WIFE Emil Ott
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Emil Ott Rt # 3 St Charles Mo.
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) Metastatic Bone Carcinoma ANTECEDENT CAUSES DUE TO (b) Carcinoma of Breast 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 Feb 21 - '49		19b. MAJOR FINDINGS OF OPERATION Carcinoma of Breast	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)
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?
22. I hereby certify that I attended the deceased from Feb 1 , 1949, to May 17 , 1950, that I last saw the deceased alive on May 17 , 1950, and that death occurred at 4 P. m., from the causes and on the date stated above.			
23a. SIGNATURE M Jenkins M.D.		23b. ADDRESS St Charles Mo	23c. DATE SIGNED 5/20/50
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE May 20 1950	24c. NAME OF CEMETERY OR CREMATORY St John's Cemetery	24d. LOCATION (City, town, or county) (State) St Charles Mo
DATE REC'D BY LOCAL REG 5/26/50	REGISTRAR'S SIGNATURE Hannie Hamilton	25. FUNERAL DIRECTOR'S SIGNATURE 284 W. Harrison	ADDRESS 620 Jefferson

(Licensed Embalmer's Statement on Reverse Side)

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

District File Number

District Health Officer No. 9,

RECEIVED
MAY 26 1950

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 Fredric W. Bane

Licensed Embalmer No. 4607

P. O. Address St. Charles

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.