

FILED MAY 17 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18765

State File No. _____

318

1003

Registrar's No. 4196

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 <u>MISSOURI</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST LOUIS</u>		c. LENGTH OF STAY (In this place) <u>2 MONS</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST LOUIS</u>		<u>2229</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST LUKES HOSPITAL</u>				d. STREET ADDRESS (If rural, give location) <u>921 HICKORY</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>DOROTHY</u> b. (Middle) _____ c. (Last) <u>WEST</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>MAY 7 1950</u>				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED-NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>NOV 23 1896</u>		9. AGE (In years last birthday) <u>53</u>	Months <u>5</u>	Days <u>14</u>
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) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>LESTER MCCLAIN</u>		13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME <u>JOHN WEST 921 HICKORY</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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Stratiation - Incontinence</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>I Entero- vaginal fistulae</u> DUE TO (c) <u>Carcinoma of Rectum</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.						INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>6 months</u> <u>18 months</u>
19a. DATE OF OPERATION <u>5 Oct 48</u>	19b. MAJOR FINDINGS OF OPERATION <u>Operable Carcinoma of Rectum</u>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) _____		21d. (COUNTY) _____		21e. (STATE) <u>MO</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED m. 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 <u>3 Oct 1948</u> , to <u>7 May 1950</u> , that I last saw the deceased alive on <u>7 May 1950</u> , and that death occurred at <u>12:54 a.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Marshall B. Conrad M.D.</u>				23b. ADDRESS <u>2535 Delmar</u>		23c. DATE SIGNED <u>5-7-50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>MAY 10 1950</u>	24c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL CEMETERY - ST. LOUIS</u>		24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS, MO.</u>			
DATE REC'D BY LOCAL <u>MAY 9 1950</u>	REGISTRAR'S SIGNATURE <u>J. B. Foster</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas Kutis 5906 Grannis</u>			

(Licensed Embalmer's Statement on Reverse Side)

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.

Signed _____
Harold C. Rice

Signed _____
Student Embalmer

Licensed Embalmer No. 4347

P. O. Address 2906 Hawaii

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.