

FILED JUN 29 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **21407**  
Registrar's No. **5330**

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>Missouri</b> b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		<b>2049</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>6413 West Park Ave.</b>			f. STREET ADDRESS (If rural, give location) <b>6413 West Park Ave.</b>		
3. NAME OF DECEASED (Type or Print) a. (First) <b>Mabel</b> b. (Middle) <b>M</b> c. (Last) <b>Brown</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>6. 16 50</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>June 27-1883</b>	9. AGE (In years last birthday) (Specify) <b>66</b>	10. MONTHS <b>6</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Fontanille Iowa</b>		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME <b>Wm Bakerink</b>		13b. MOTHER'S MAIDEN NAME <b>Ada Verb</b>		14. NAME OF HUSBAND OR WIFE <b>late Robert R. Brown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Aurel Harrison 6413 West Park Ave</b>		
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 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of Left Breast</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) <b>Extensive Metastasis to Lungs - Right Breast Axillary Glands and neck.</b> DUE TO (c)  11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>  <b>1 year</b>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>No operation</b>			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) <b>August 1950</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>170X</b>			
22. I hereby certify that I attended the deceased from <b>August, 1949, to June 16, 1950</b> , that I last saw the deceased alive on <b>June 15, 1950</b> , and that death occurred at <b>9 P. m.</b> , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <b>J. H. Norton, M.D.</b>			23b. ADDRESS <b>634 No Grand - St. Louis Mo.</b>		23c. DATE SIGNED <b>6-17-50</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>6-19-1950</b>	24c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo</b>		
DATE REC'D BY LOCAL REG. <b>JUN 19 1950</b>	REGISTRAR'S SIGNATURE <b>J. B. Pasater</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Leidner U. 2223 St. Louis Ave.</b>		

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

*Bliss H. Radford*

Licensed Embalmer No. *4077*

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.