

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED SEP 22 1950

State File No. **31831**  
Registrar's No. **7716**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo.</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place) <b>Life</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		<b>2057</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. John's Hospital</b>				d. STREET ADDRESS (If rural, give location) <b>5 5789 Waterman Ave.</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Oscar</b>			b. (Middle) <b>J.</b>		c. (Last) <b>Mudd</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Sept. 11, 1950</b>
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>M.</b>		8. DATE OF BIRTH <b>Aug. 22, 1889</b>	9. AGE (In years) (last birthday) <b>61</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>19</b> Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Stationery</b>		11. BIRTHPLACE (State or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13a. FATHER'S NAME <b>Oscar J. Mudd</b>			13b. MOTHER'S MAIDEN NAME <b>Theresa B. Seibert</b>		14. NAME OF HUSBAND OR WIFE <b>Mrs. Florence Mudd</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>Mrs. Florence Mudd, 5789 Waterman 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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pulmonary atelectasis &amp; edema</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Fibro-sarcoma both lungs. Metastatic</b> DUE TO (c) <b>Fibro-sarcoma chest wall</b> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>well</b>				INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>6 mon</b> <b>1 yr.</b>	
19a. DATE OF OPERATION <b>June 1949</b>		19b. MAJOR FINDINGS OF OPERATION: <b>Fibro-sarcoma Rt. Chest wall</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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>1991</b>			
22. I hereby certify that I attended the deceased from <b>June</b> , 19 <b>49</b> , to <b>Sept 11</b> , 19 <b>50</b> , that I last saw the deceased alive on <b>Sept 11</b> , 19 <b>50</b> , and that death occurred at <b>10 a.</b> m., from the causes and on the date stated above.							
23a. SIGNATURE <b>[Signature]</b> (Degree or title) <b>MD</b>				23b. ADDRESS <b>4952 Mayland Ave</b>		23c. DATE SIGNED <b>9/11/50</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial (1)</b>		24b. DATE <b>Sept. 13, 1950</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>SEP 12 1950</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur J. Donnelly</b>		ADDRESS <b>840 Lindell Blvd.</b>	

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

Dr. A. Oranger  
4952 Mariposa Road  
San

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.....  
*W. Van Matre*

Licensed Embalmer No. *2825*

P. O. Address *4340 Lafayette*

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.