

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **32097**

FILED OCT 10 1950

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **3069** Registrar's No. **2278**

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
a. COUNTY St. Louis	a. STATE Missouri		b. COUNTY St. Louis
b. CITY (If outside corporate limits, write RURAL and give township) Richmond Heights	c. LENGTH OF STAY (In this place) 27	c. CITY (If outside corporate limits, write RURAL and give township) Overland 4241	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Mary's Hospital		d. STREET ADDRESS (If rural, give location) 3974 Wright	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH (Month) (Day) (Year)		
(a) (First) Lucy	(b) (Middle) Terbreck	(c) (Last) Terbreck	Sept. 23 1950		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Feb. 7 1896		9. AGE (In years last birthday) 54
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Luetsville Missouri		12. CITIZENRY OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Joseph Seiler	13b. MOTHER'S MAIDEN NAME Anne Thole	14. NAME OF HUSBAND OR WIFE John Terbreck
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. --	17. INFORMANT'S SIGNATURE OR NAME John Terbreck
		ADDRESS 3974 Wright

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 years
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) General Carcinomatosis		
	ANTECEDENT CAUSES As forbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma of Breast DUE TO (c) Metastasis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		170A	

19a. DATE OF OPERATION 9/5/49	19b. MAJOR FINDINGS OF OPERATION Carcinoma Rt 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) (m.)	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 July 7th 1949, to Sept. 23, 1950, that I last saw the deceased alive on Sept 22, 1950, and that death occurred at 1:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Dr. Arnold A. Wainwright, M.D.	23b. ADDRESS 3115 Brown Rd	23c. DATE SIGNED 9/23/50
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sept. 25	24c. NAME OF CEMETERY OR CREMATORY Calvary
24d. LOCATION (City, town, or county) (State) St. Louis Missouri		25. FUNERAL DIRECTOR'S SIGNATURE Ortmann Funeral Home
DATE REC'D BY LOCAL REG. 9-24-50	REGISTRAR'S SIGNATURE Herbert R. Donke M.D.	ADDRESS 9222 Lackland

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.....
Student Embalmer

Signed Al C. Ortmanis

Licensed Embalmer No. 3478

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.