

FILED NOV 2 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34816

State File No. ....

318

1003

9157

|  |                               |   |   |  |   |  |  |
|--|-------------------------------|---|---|--|---|--|--|
| BIRTH NO. _____  |                               | REG. DIST. NO. _____  |   | PRIMARY REG. DIST. NO. _____   |   | Registrar's No. _____  |  |
| 1. PLACE OF DEATH<br>a. COUNTY _____   |                               |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)<br>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) _____   |   | f. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>                                      |   | g. _____ <u>2089</u>   |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>8657 Partridge Ave.</u>  |                               |   |   | d. STREET ADDRESS (If rural, give location) <u>8657 Partridge Ave. 6</u>   |   |  |  |
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) <u>Isabell</u> b. (Middle) _____ c. (Last) <u>Becker</u>   |                               |   | 4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 15 1951</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>June 9-1890</u>                       |  | 9. AGE (In years last birthday) <u>61</u> | if UNDER 1 YEAR Months <u>4</u> Days <u>5</u>  | if UNDER 6 Hrs. Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>House Work</u>   |   | 11. BIRTHPLACE (State or foreign country) <u>St. Louis Mo</u>  |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>  |  |
| 13a. FATHER'S NAME <u>Not Known</u>  |                               | 13b. MOTHER'S MAIDEN NAME <u>Marguret Schad</u>   |   | 14. NAME OF HUSBAND OR WIFE <u>Charles Becker</u>  |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, so, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>none</u>   |                               | 16. SOCIAL SECURITY NO. <u>None</u>   |   | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. John Kottwinkel 8657 Partridge</u>   |   |  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Generalized CARCINOMA TOSIS</u><br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <u>CARCINOMA uterus</u><br><br>DUE TO (c) _____<br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <u>Lymphatic obstruction leg</u> |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>6 months</u><br><br><u>?</u><br><br><u>3 months</u> |  |
| 19a. DATE OF OPERATION <u>JAN. 1951</u>  |                               | 19b. MAJOR FINDINGS OF OPERATION <u>CARCINOMA uterus (endometrium)</u>  |   |  |   | 20. AUTOPSY?<br>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? <u>172X</u>   |   |  |  |
| 22. I hereby certify that I attended the deceased from <u>Dec. 1950</u> , to <u>Oct 15, 1951</u> , that I last saw the deceased alive on <u>Oct 13, 1951</u> , and that death occurred at <u>8 A</u> m., from the causes and on the date stated above. |                               |   |   |  |   |  |  |
| 23a. SIGNATURE (Degree or title) <u>Harold C. Selle M.D.</u>   |                               |   |   | 23b. ADDRESS <u>5626 W. Florissant</u>   |   | 23c. DATE SIGNED <u>10/15/51</u>   |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                               | 24b. DATE <u>Oct. 17, 1951</u>  |   | 24c. NAME OF CEMETERY OR CREMATORY <u>Bellefontaine</u>  |   | 24d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri.</u>                  |  |
| DATE REC'D BY LOCAL REG. <u>OCT 17 1951</u>  |                               | REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>   |   | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Buchholz-Koeller 5967 W. Florissant</u>  |   |  |  |

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 J. Wm Binkley  
Licensed Embalmer No. 3653  
P. O. Address St Louis Mo

**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.