

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED NOV 8 1951

State File No. 35257  
Registrar's No. 9517

BIRTH NO. \_\_\_\_\_ 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 Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital		d. STREET ADDRESS (If rural, give location) 3935a Dunnica	

3. NAME OF DECEASED (Type or Print) a. (First) Anna b. (Middle) Kenkel c. (Last) Kenkel

4. DATE OF DEATH (Month) (Day) (Year) 10/27/51

5. SEX Female 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, SEPARATED Married

8. DATE OF BIRTH Apr. 14, 1892 9. AGE (In years last birthday) 59

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home

10b. KIND OF BUSINESS OR INDUSTRY ---

11. BIRTHPLACE (State or foreign country) St. Louis, Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME John Sinko 13b. MOTHER'S MAIDEN NAME Anna Somfik 14. NAME OF HUSBAND OR WIFE Raymond

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No

16. SOCIAL SECURITY NO. ---

17. INFORMANT'S SIGNATURE OR NAME ADDRESS Raymond Kenkel--3935a Dunnica

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH\* (a) *Generalized Carcinomatosis*

ANTECEDENT CAUSES (b) *Papillary cyst adenocarcinoma of ovary. & metastasis*

II. OTHER SIGNIFICANT CONDITIONS (c) *Conditions contributing to the death but not related to the disease or condition causing death.*

INTERVAL BETWEEN ONSET AND DEATH 8/5/50.

19a. DATE OF OPERATION 8/5/50

19b. MAJOR FINDINGS OF OPERATION *Papillary cyst adenocarcinoma bilateral metastasis*

20. AUTOPSY? YES  NO

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  NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? 175X

22. I hereby certify that I attended the deceased from Aug 3, 1950, to Oct 27, 1951; that I last saw the deceased alive on Oct 26, 1951, and that death occurred at 3:45a m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Elbert H. Cason M.D.

23b. ADDRESS 3606 Fernwood

23c. DATE SIGNED 10/27/51

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 10/27/51

24c. NAME OF CEMETERY OR CREMATORY Resurrection Cem.

24d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri

DATE REC'D BY LOCAL REG. OCT 29 1951

REGISTRAR'S SIGNATURE Earl Smith

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wacker-Heldule 3634 Gravois

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

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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.....

*Frank J. McLaughlin Sr.*

Licensed Embalmer No. *2675*

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.