

FILED JAN 16 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43224**
Registrar's No. **11706**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

I. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, write RURAL and give town) **ST LOUIS**

c. LENGTH OF STAY (in this place)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

a. STATE **Mo**

b. COUNTY **9719**

c. CITY (If outside corporate limits, write RURAL and give township) **ST LOUIS**

d. STREET ADDRESS (If rural, give location) **1314 N. Harrison**

d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION **HOMER P. Phillips**

3. NAME OF DECEASED (Type or Print)

a. (First) **Virginia**

b. (Middle)

c. (Last) **Oden**

4. DATE OF DEATH (Month) (Day) (Year) **12-29-51**

5. SEX **FEM**

6. COLOR OR RACE **Col.**

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **MARRIED**

8. DATE OF BIRTH **7/4/1888**

9. AGE (In years last birthday) **63** IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

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

10b. KIND OF BUSINESS OR INDUSTRY **Home Keeper**

11. BIRTHPLACE (State or foreign country) **Greensboro Ala.**

12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME **Unknown**

13b. MOTHER'S MAIDEN NAME **Melvinia Kenealy**

14. NAME OF HUSBAND OR WIFE **Wm M Oden**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, specify) (If yes, give year or dates of service) **No**

16. SOCIAL SECURITY NO. **None**

17. INFORMANT'S SIGNATURE OR NAME ADDRESS **Wm M Oden 1314 N Harrison**

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

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

MEDICAL CERTIFICATION

Carcinoma of Breast - metastatic

INTERVAL BETWEEN ONSET AND DEATH **7 mo.**

ANECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

marked edema of neck

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

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? **170X**

22. I hereby certify that I attended the deceased from **9-15**, 1951, to **12/28**, 1951, that I last saw the deceased alive on **12/28**, 1951, and that death occurred at **3:30** m., from the causes and on the date stated above.

23a. SIGNATURE (Deed or Title) **J. F. Benson M.D.**

23b. ADDRESS **4242 Easton Ave**

23c. DATE SIGNED **12/31/51**

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

24b. DATE **Jan. 2, 1952**

24c. NAME OF CEMETERY OR CREMATORY **Washington Park**

24d. LOCATION (City, town, or county) (State) **St Louis Co. 9700 W. Bridge MO**

DATE REC'D. BY LOCAL **DEC 31 1951**

REGISTRAR'S SIGNATURE **J. Earl Smith**

FUNERAL DIRECTOR'S SIGNATURE ADDRESS **L. W. Bruce 4469 Washington Blvd**

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.

Signed.....

Frederick P. Stack

Signed.....

Student Embalmer

Licensed Embalmer No. *4599*

P. O. Address *St. Louis*

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.