

FILED APR 25 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 14148
Registrar's No. 3060

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 2149	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4994 A. Potomac St		d. STREET ADDRESS (If rural, give location) 14 4994 A. Potomac St	
3. NAME OF DECEASED (Type or Print) a. (First) Alice b. (Middle) May c. (Last) Conlin		4. DATE OF DEATH (Month) (Day) (Year) 3-30-1952	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 3-15-1895
9. AGE (In years last birthday) 57		IF UNDER 1 YEAR Months	IF UNDER 4 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME Edward C. Lewis		13b. MOTHER'S MAIDEN NAME Laura Munge	14. NAME OF HUSBAND OR WIFE Weaver Conlin
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. None	17. INFORMANT'S SIGNATURE OR NAME Weaver Conlin ADDRESS 4994 A. Potomac St
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) Carcinoma of Liver + Stomach INTERVAL BETWEEN ONSET AND DEATH 3 months ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma of Breast - Primary 8 months DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Lochia - Stomatitis	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR 170X
22. I hereby certify that I attended the deceased from 3-26 , 19 52 , to 3-30 , 19 52 , that I last saw the deceased alive on 3-30 , 19 52 , and that death occurred at 5:35 Pm. , from the causes and on the date stated above.			
23a. SIGNATURE John Lawrence (Degree or title) MD		23b. ADDRESS 634 No Grand Ave	23c. DATE SIGNED 3-31-52
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 4-2-1952	24c. NAME OF CEMETERY OR CREMATORY Bellefontaine Cemetery	24d. LOCATION (City, town, or county) (State) 4947 W. Florissant Ave Mo
DATE RECD BY LOCAL REG. APR 1 1952	REGISTRAR'S SIGNATURE J. Carl Smith MD	FUNERAL DIRECTOR'S SIGNATURE ADDRESS Biegeheuer Bros. 6409 Gravois Ave	

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

No. Theatre Building
UJ 7197

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.....

John M. Simon

Licensed Embalmer No.....

4343

P. O. Address.....

St. Louis, Mo.

Signed.....
Student Embalmer

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.