No. 300
10.48

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

FILED JUL 22 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26442

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 6692

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place): 5 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION: Barnard Free Skin & Cancer Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
d. STREET ADDRESS (If rural, give location): 3428 Klein

2209

26

3. NAME OF DECEASED (Type or Print)
a. (First): Flora
b. (Middle): E.
c. (Last): Wade

4. DATE OF DEATH (Month): 7 (Day): 9 (Year): 52

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 3
8. DATE OF BIRTH: Sept. 12, 1904
9. AGE (In years last birthday): 47 — If under 1 year: Months 9, Days 27 — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Tennessee?
12. CITIZEN OF WHAT COUNTRY?: U.S.

13a. FATHER'S NAME: William W. Powell
13b. MOTHER'S MAIDEN NAME: Fannie Wyatt
14. NAME OF HUSBAND OR WIFE: Charles

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unknown (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 411-38-7155
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: Hospital Record - Barnard Hospital

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b), and (c)

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. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Reticulum cell Sarcoma (metastatic)

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Mycosis Fungoides
DUE TO (c):

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

INTERVAL BETWEEN ONSET AND DEATH

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?

205X

22. *I hereby certify that I attended the deceased from* 7-2-, *19* 52, *to* 7-9, *19* 52, *that I last saw the deceased alive on* 7-2, *19* 52, *and that death occurred at* 205 A *m., from the causes and on the date stated above.*

23a. SIGNATURE George Manning (Degree or title) M.D.
23b. ADDRESS: Barnard Hospital - St. Louis, Mo.
23c. DATE SIGNED: 7-9-52

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 7-9-52
24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) (State): Paris, Tenn.

DATE REC'D BY LOCAL REG. JUL 10 1952
REGISTRAR'S SIGNATURE: Carl Smith M.D.
M.B.
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Albert H. Hoppe, 4700 Washington Blvd.

(Licensed Embalmer's Statement on Reverse Side)

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 S. Lemmel

Signed.....
Student Embalmer

Licensed Embalmer No. 4194

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.