

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 29558
7797

BIRTH NO.		REG. DIST. NO. 318	PRIMARY REG. DIST. NO. 1003	Registrar's No.
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 0		a. STATE Missouri	b. COUNTY St. Louis	4171
c. LENGTH OF STAY (In this place) 3 Mo.		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Ann		
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Baptist Hospital		d. STREET ADDRESS (If rural, give location) 3462 St. William La.		
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH	
a. (First) Loraine	b. (Middle) E.	c. (Last) Haverkost	Aug. 14, 1952	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH April 7, 1899	9. AGE (In years last birthday) 53
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Fulton Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Eugene White		13b. MOTHER'S MAIDEN NAME Caroline Glover	14. NAME OF HUSBAND OR WIFE William Haverkost	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME ADDRESS William Haverkost 3462 St. William La.	
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) Carcinomatosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma of left breast 2 years. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary edema		INTERVAL BETWEEN ONSET AND DEATH 2 years
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 Feb. 12, 1952, to Aug. 14, 1952, that I last saw the deceased alive on 8/14, 1952, and that death occurred at 5 P. M., from the causes and on the date stated above.				
23a. SIGNATURE (Degree or title) William A. Jones M.D.		23b. ADDRESS 3720 Washington	23c. DATE SIGNED 8/15/52	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8/18/52	24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis County Mo.	
DATE REC'D BY LOCAL REG. 1 5 1952	REGISTRAR'S SIGNATURE J. Earl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Collier's Funeral Home 10123 St. Charles, Mo.		

(Licensed Embalmer's Statement on Reverse Side)

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 _____

Sheldon Collier

Licensed Embalmer No. 3382

P. O. Address 10123 St. Chas

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.