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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 28 1953

State File No. **3711**
Registrar's No. **26**

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

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 26	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) TOWNSHIP 3 DAYS		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2019	
d. FULL NAME OF HOSPITAL OR INSTITUTION DRACONER				d. STREET ADDRESS (If rural, give location) 4105 BLOW			
3. NAME OF DECEASED (Type or Print) a. (First) Rosalie b. (Middle) G c. (Last) SARGENT			4. DATE OF DEATH (Month) (Day) (Year) JAN 2 1953				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH MAY 29 1901		9. AGE (In years last birthday) 51	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (City and State or Foreign Country) LIMA PERU S.A		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13a. FATHER'S NAME MANUEL GARCIA GURAPA			13b. MOTHER'S MAIDEN NAME M. R		14. NAME OF HUSBAND OR WIFE Roy		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NO		17. INFORMANT'S SIGNATURE OR NAME Mrs. Manfred Fernandez		ADDRESS 4105 BLOW	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)				MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Breast				DUPLICATE			
ANTECEDENT CAUSES				DUPLICATE			
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				DUPLICATE			
II. OTHER SIGNIFICANT CONDITIONS* (b) (c)				DUPLICATE			
Conditions contributing to the death but not related to the disease or condition causing death.				DUPLICATE			
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 1948 , to 1-2-53 , that I last saw the deceased alive on 1-1-53 , and that death occurred at 9:45 A.M. , from the causes and on the date stated above.							
23a. SIGNATURE W. W. Eades MD. (Degree or title)			23b. ADDRESS 2602 S Brady			23c. DATE SIGNED 1-3-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE JAN 5 53	24c. NAME OF CEMETERY OR CREMATORY GALLVARY		24d. LOCATION (City, town, or county) (State) St. Louis MO.		
DATE REC'D BY LOCAL REG. JAN 3 1953		REGISTRAR'S SIGNATURE J. C. Smith MD.		25. FUNERAL DIRECTOR'S SIGNATURE Cullen Kelly		ADDRESS 4386 Lindell	

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

(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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed James G. Lammers

Licensed Embalmer No. 4142

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.