

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12399

State File No. _____

FILED MAR 18 1953

1003

2003

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. _____ 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 <u>St. Louis, Missouri</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis City Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>25 204^a No. 18th St.</u>	

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
<u>HAZEL</u>			<u>TAYLOR</u>	<u>FEBRUARY 19, 1953</u>

5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Mar. 30. 1908</u>	9. AGE (In years last birthday) <u>44</u>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HRS. Hours	IF UNDER 1 HRS. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Unknown</u>	13b. MOTHER'S MAIDEN NAME <u>McCrady</u>	13c. NAME OF HUSBAND OR WIFE <u>William Taylor</u>
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14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>William Taylor</u>	17. ADDRESS <u>204^a No. 18th St.</u>
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Metastatic carcinoma</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Cystadenocarcinoma of right ovary</u> DUE TO (c) <u>Adenocarcinoma, left breast</u> Conditions contributing to the death but not related to the disease or condition causing death. <u>Rheumatic heart disease.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 years</u> <u>1 year</u> <u>15-20 years?</u>
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19a. DATE OF OPERATION <u>9/30/52</u>	19b. MAJOR FINDINGS OF OPERATION <u>Large bluish ovary with peritoneal metastases</u>	20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>175X.</u>

22. I hereby certify that I attended the deceased from 12-18-52, 19, to 2-19-53, 19, that I last saw the deceased alive on 2-19-53, 19, and that death occurred at 9:20A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Wm. H. Brady, M.D.</u>	23b. ADDRESS <u>1515 Lafayette Avenue</u>	23c. DATE SIGNED <u>2-19-53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>2/21/53</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Walnut Hill Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>Petersburg, Indiana</u>
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DATE REC'D BY LOCAL <u>FEB 20 1953</u>	REGISTRAR'S SIGNATURE <u>Carl Smith</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Provost and Co.</u>	ADDRESS <u>3910 No. Grand</u>
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(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

Stanley H. Dixon

Licensed Embalmer No. *4193*

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.