

STANDARD CERTIFICATE OF DEATH

State File No.

No. 300
10.48

FILED MAR 18 1953

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **2277**

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

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, Missouri		c. LENGTH OF STAY (in this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION Firmin Desloge Hospital		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2109	
3. NAME OF DECEASED (Type or Print) Margaret		d. STREET ADDRESS (If rural, give location) 10 3714 Cora	
a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) Feb. 26, 1953
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed.	8. DATE OF BIRTH 10-10-90
9. AGE (in years) (last birthday) 62		10. KIND OF BUSINESS OR INDUSTRY	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (City and State or Foreign Country) Illinois. Chatam	
12. CITIZEN OF WHAT COUNTRY? U.S.		13a. FATHER'S NAME Whelan, Martin	
13b. MOTHER'S MAIDEN NAME Cassidy, Mary Ann		14. NAME OF HUSBAND OR WIFE Wilson, Byron	
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.	
17. INFORMANT'S SIGNATURE OR NAME John Wilson		ADDRESS 3714 Cora Ave.	
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 (Primary in rt. ovary &/or left lung) ANTECEDENT CAUSES metastases to Heart, pericardium, opposite chest lung, Kidneys, pleura, diaphragm, thoracic. DUE TO (b) opposite chest lung, Kidneys DUE TO (c) nodes and rt. adrenal II. OTHER SIGNIFICANT CONDITIONS CHR. CHOLECYSTITIS & CHOLELITHIASIS ADENOMA OF LEFT ADRENAL CHR. PROCTITIS & ULCERATION	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
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)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 175x	
22. I hereby certify that I attended the deceased from Feb. 17, 1953 , to Feb. 26, 1953 , that I last saw the deceased alive on Feb. 25, 1953 , and that death occurred at 10:20 Am. , from the causes and on the date stated above.			
23a. SIGNATURE Blaynd		23b. ADDRESS 1325 Sth. Grand. St. Louis, MO.	
23c. DATE SIGNED 2-27-53		(Degree or title) MD. O	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 3/2/53	
24c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY		24d. LOCATION (City, town, or county) (State) ST. LOUIS MISSOURI	
DATE REC'D BY LOCAL REG. FEB 28 1953		25. FUNERAL DIRECTOR'S SIGNATURE Stroot - Carroll	
REGISTRAR'S SIGNATURE Carl Smith MD		ADDRESS 4600 NATURAL BRIDGE AVE	

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 Albert Mayfield

Licensed Embalmer No. D 3077

P. O. Address St. Louis Mo

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.