.300
.48

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

FILED JUL 31 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26292

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 6671

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): 12 wks.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Anthony Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis
d. STREET ADDRESS (If rural, give location): 5433 Rosa

2029/0

3. NAME OF DECEASED (Type or Print)
a. (First): Elsie
b. (Middle): M
c. (Last): Duwe

4. DATE OF DEATH (Month) (Day) (Year): July 4, 1953

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Sept 12, 1894
9. AGE (In years last birthday): 58 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Mediapolis, Iowa
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Frank McDonald
13b. MOTHER'S MAIDEN NAME: Clara Ryker
14. NAME OF HUSBAND OR WIFE: Albert Duwe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME: Albert Duwe — ADDRESS: 5433 Rosa

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, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Carcinoma of Breast — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Myocardial infarction — 3 mo

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing 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): 170 X
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-15, 1952, *to* 7-3, 1953, *that I last saw the deceased alive on* 7-3, 1953, *and that death occurred at* 4:30 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE Esther Within MD (Degree or title)
23b. ADDRESS: 4145 S Grand
23c. DATE SIGNED: 7-6-53

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7/7/53
24c. NAME OF CEMETERY OR CREMATORY: N St Marcus Cemetery
24d. LOCATION (City, town, or county) (State): St Louis Mo.

DATE REC'D BY LOCAL REG.: JUL 6 1953
REGISTRAR'S SIGNATURE: H Carl Smith MD
25. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: J L Ziegenhein & Sons 7027 Gravois
(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 C. P. Kidwell

Licensed Embalmer No. 3877

P. O. Address 7027 Gravoi

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.