

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **40279**
REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10998**

FILED NOV 27 1953

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 2157	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS Mo		c. CITY OR TOWN ST. LOUIS d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION MARIAN HOSPITAL		e. STREET ADDRESS (If rural, give location) 4525 OREGON	
3. NAME OF DECEASED (Type or Print) a. (First) PEARL b. (Middle) A. c. (Last) CHAPHE		4. DATE OF DEATH (Month) (Day) (Year) Nov. 18 1953	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH OCT 19 1905
9. AGE (In years last birthday) 48		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HAIRDRESSER	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and State or Foreign Country) NEBRASKA		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME CHARLES KRUEGER		13b. MOTHER'S MAIDEN NAME UNKNOWN	
14. NAME OF HUSBAND OR WIFE HOMER L. CHAPHE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	
16. SOCIAL SECURITY NO. 489-01-8958		17. INFORMANT'S SIGNATURE OR NAME HOMER L. CHAPHE ADDRESS 4525 OREGON	
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) Tumor of the Ovaries ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) (Type unknown) 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 2/3/52		19b. MAJOR FINDINGS OF OPERATION tumor of the Ovaries	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. ACCIDENT SUICIDE HOMICIDE (Specify)	
21a. 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? 237X		22. I hereby certify that I attended the deceased from 9/17 , 19 53 , to 11/18 , 19 53 , that I last saw the deceased alive on 11/17 , 19 53 , and that death occurred at 3 P m., from the causes and on the date stated above.	
23a. SIGNATURE Dr. A. Hester (Degree or title)		23b. ADDRESS 5600 A Compton	
23c. DATE SIGNED 11/19/53		24. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL 24b. DATE Nov 20 1953 24c. NAME OF CEMETERY OR CREMATORY LAUREL HILL GARDENS 24d. LOCATION (City, town, or county) (State) ST. LOUIS Mo	
DATE REC'D BY LOCAL REG. NOV 19 1953		REGISTRAR'S SIGNATURE J. Earl Smith 25. FUNERAL DIRECTOR'S SIGNATURE Thomas Lutie ADDRESS 2906 Lewis	

5600 A. Darnham
No. 3383
2:15 to 5:00 p.m. - Illinois.

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.....
Signature of Student Embalmer

Signed *James C. Hill*.....

Licensed Embalmer No. *4347*.....

P. O. Address *2906 Hill*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.