

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41558

State File No.

FILED NOV 25 1953

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>547</u>		Registrar's No. <u>2779</u>	
1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town or township) <u>RICHMOND HEIGHTS</u>		c. LENGTH OF STAY (in this place) <u>1 DAY</u>		c. CITY OR TOWN <u>ST. LOUIS</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST MARYS HOSPITAL</u>				e. STREET ADDRESS (If rural, give location) <u>5801A EASTON AVE</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>ANNA</u> b. (Middle) <u>EUPHEMIA</u> c. (Last) <u>JAMES</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>10-26-1953</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>4-12-1874</u>		9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 1 HR. Hours _____ Min. _____
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>AT HOME</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>LEXINGTON KY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>THOMAS FINNEY</u>			13b. MOTHER'S MAIDEN NAME <u>EFFIE BLACK</u>		14. NAME OF HUSBAND OR WIFE <u>OLIVER C. JAMES</u>		
15. 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>UNK</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs L. Drews 43 Hillvale Clayton</u>			
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>Abdominal Carcinoma</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Ovarian Carcinoma</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Cholecystitis.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u>
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <u>175X</u>	
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?			
22. I hereby certify that I attended the deceased from <u>Oct 21, 1953</u> , to <u>Oct 26, 1953</u> , that I last saw the deceased alive on <u>Oct 25, 1953</u> , and that death occurred at <u>1309</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>W. H. Schmitt M.D.</u>				23b. ADDRESS <u>508 N. Grand Ave</u>		23c. DATE SIGNED <u>10/27/53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		24b. DATE <u>10-28-1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>VALHALLA CREMATORY</u>		24d. LOCATION (City, town, or county) (State) <u>ST LOUIS MO</u>		
DATE REC'D BY LOCAL REG. <u>10/28/53</u>		REGISTRAR'S SIGNATURE <u>Walter C. ...</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Walter C. ...</u> <u>F. Home Webster</u> <u>Grand</u> <u>MO.</u>			

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 NO embalming Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Leslie Welch.....
Licensed Embalmer No. 439
P. O. Address Helena, Mont.

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.