

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6043

FILED MAR 8 1954 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 1915

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE ILLINOIS b. COUNTY Madison	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN SAINT LOUIS, MO		c. CITY OR TOWN GRANITE CITY	
c. LENGTH OF STAY (in this place)		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 MISSOURI PACIFIC HOSPITAL AND		e. STREET ADDRESS (If rural, give location) 2133 Washington 81208	

3. NAME OF DECEASED (Type or Print) a. (First) GARNET b. (Middle) LUCILLE c. (Last) COMPTON			4. DATE OF DEATH (Month) (Day) (Year) February 28 1954		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH May 25, 1908		9. AGE (In years last birthday) 45		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 At Home		11. BIRTHPLACE (City and State or Foreign Country) Flora, Ill.	
12. CITIZEN OF WHAT COUNTRY? U.S.					

13a. FATHER'S NAME Floyd Hoskins		13b. MOTHER'S MAIDEN NAME Maude Hargraves		14. NAME OF HUSBAND OR WIFE Robert F. Compton	
----------------------------------	--	---	--	---	--

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. 525-08-2068		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Robert F. Compton, Granite City, Ill.	
---	--	-------------------------------------	--	---	--

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 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) METASTATIC CARCINOMA ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Stage IV Cancer of the Uterine Cervix DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
---	--	--	--	--	--	----------------------------------	--

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
------------------------	--	----------------------------------	--	--	--	---	--

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? 171X	

22. I hereby certify that I attended the deceased from 2-17, 1954, to 2-28, 1954, that I last saw the deceased alive on 2-27, 1954, and that death occurred at 12:45 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) [Signature] MD		23b. ADDRESS 1755 So Grand		23c. DATE SIGNED 2-28-54	
---	--	----------------------------	--	--------------------------	--

24a. BURIAL, CREMATION, REMOVAL Removal		24b. DATE 2-28-54		24c. NAME OF CEMETERY OR CREMATORY Elmwood		24d. LOCATION (City, town, or county) (State) Flora, Ill.	
---	--	-------------------	--	--	--	---	--

DATE REC'D BY LOCAL REG. MAR 1 1954		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd.	
-------------------------------------	--	-----------------------------------	--	---	--

(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.....
Signature of Student Embalmer

Signed *Paul G. Wachter*.....

Licensed Embalmer No. *476*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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