

FILED APR 29 1954

STANDARD CERTIFICATE OF DEATH

State File No. 13764

Registrar's No. 3733

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. 13764		Registrar's No. 3733		
1. PLACE OF DEATH a. COUNTY <i>Deaconess Hospital</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <i>Missouri</i> b. COUNTY _____						
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>St. Louis</i>		c. LENGTH OF STAY (in this place) <i>2 Weeks</i>		c. CITY OR TOWN <i>St. Louis</i>		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 <i>Deaconess Hospital</i>				e. STREET ADDRESS (If rural, give location) <i>7039 Nashville Ave 2049</i>						
3. NAME OF DECEASED (Type or Print) a. (First) <i>MAE</i> b. (Middle) <i>MARY</i> c. (Last) <i>McCONNELL</i>			4. DATE OF DEATH (Month) (Day) (Year) <i>April 23 1954</i>							
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>May 17 1916</i>		9. AGE (in years last birthday) <i>37</i>	if UNDER 1 YEAR Months <i>11</i>	if UNDER 1 YEAR Days <i>6</i>	if UNDER 1 HR. Hours <i></i> Min. <i></i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (City and State or Foreign Country) <i>St. Louis, Mo</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>				
13a. FATHER'S NAME <i>George Joseph Kaiser</i>			13b. MOTHER'S MAIDEN NAME <i>Rosal Decker</i>			13c. NAME OF HUSBAND OR WIFE <i>Dwight F. McConnell</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT'S SIGNATURE OR NAME <i>Dwight F. McConnell</i> ADDRESS _____						
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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Carcinoma Breast</i>						INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs.</i>			
	ANTECEDENT CAUSES A forbidding conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____									
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>metastases to lungs.</i>									
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) <i>170X</i>						
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? _____						
22. I hereby certify that I attended the deceased from <i>Apr</i> , 19 <i>54</i> , to <i>Apr</i> , 19 <i>54</i> , that I last saw the deceased alive on <i>4/23/54</i> , 19____, and that death occurred at <i>5P</i> m., from the causes and on the date stated above.										
23a. SIGNATURE (Degree or title) <i>Rose Saue MD</i>				23b. ADDRESS <i>Deaconess Hospital</i>			23c. DATE SIGNED <i>4-24-54</i>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		24b. DATE <i>April 26 1954</i>	24c. NAME OF CEMETERY OR CREMATORY <i>Memorial Park</i>		24d. LOCATION (City, town, or county) (State) <i>St. Louis County</i>					
DATE REC'D BY LOCAL REG. <i>APR 26 1954</i>		REGISTRAR'S SIGNATURE <i>J. Carl Smith MD</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>W. H. Backlage</i> ADDRESS <i>6536 Clayton Rd</i>						

(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.....
Fred J. Turner

Licensed Embalmer No.....
478

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.