

FILED JUL 1 - 1954

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

20962

State File No.

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

Registrar's No. **4566**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY St Louis	
b. CITY (If outside corporate limits, write RURAL and give township) St Louis		c. CITY (If outside corporate limits, write RURAL and give township) Overland 423X	
d. FULL NAME OF HOSPITAL OR INSTITUTION St Lukes Hosp		d. STREET ADDRESS (If rural, give location) 9718 Midland	
3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) Maynard c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) May 21 1954
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Dec 5 1896
9. AGE (In years last birthday) 57		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary	10b. KIND OF BUSINESS OR INDUSTRY Union Electric
11. BIRTHPLACE (City and State or Foreign Country) Bowling Green, Kentucky		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Harry Maynard		13b. MOTHER'S MAIDEN NAME Kathryn Seely	14. NAME OF HUSBAND OR WIFE
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. 191-07-2029	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Kathryn Maynard Overland
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) Carcinoma of left breast		INTERVAL BETWEEN ONSET AND DEATH 3 mo.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) 2 metastases of brain, DUE TO (c) lung, dorsal spine		
	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 <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)	
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? 170X	
22. I hereby certify that I attended the deceased from 4-22 , 19 54 , to 5-21 , 19 54 , that I last saw the deceased alive on 5-21 , 19 54 , and that death occurred at 5:10 m., from the causes and on the date stated above.			
23a. SIGNATURE Clara Becke		23b. ADDRESS (Degree or title) M.D. 3720 Washington	23c. DATE SIGNED 5-21-54
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE May 26, 1954	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St Louis Mo
DATE REC'D BY LOCAL REG. MAY 21 1954	REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. F. Home 9222 Lackland

WRITE PLAINLY—USING UNFAADING 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
Student Embalmer

Signed Al C. Ostmann

Licensed Embalmer No. 3478

P. O. Address _____

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