

FILED OCT 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35300**
Registrar's No. **9491**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 9491	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) _____		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 St. John's Hospital				STREET ADDRESS (If rural, give location) 17 4104 Castleman Ave. 2179			
3. NAME OF DECEASED (Type or Print) MARGARET		a. (First) _____		b. (Middle) E.		c. (Last) DETCHEMENDY	
4. DATE OF DEATH Oct. 17 1954		(Month) _____		(Day) _____		(Year) _____	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH Aug. 20, 1902	
9. AGE (In years last birthday) 52		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 YEAR Hours _____ Min. _____		12. CITIZEN OF WHAT COUNTRY? _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Proof Claim Investigator-Gen'l. Amer. Life Ins.				10b. KIND OF BUSINESS OR INDUSTRY _____			
11. BIRTHPLACE (City and State or Foreign Country) Flat River, Mo.				12. CITIZEN OF WHAT COUNTRY? _____			
13a. FATHER'S NAME Robert C. Detchemendy		13b. MOTHER'S MAIDEN NAME Margaret Rooney		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. _____		17. INFORMANT'S SIGNATURE OR NAME E. Detchemendy ADDRESS 4104 Castleman Ave.			
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) Carcinomatous ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma Breast 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 2 1/2 yrs	
19a. DATE OF OPERATION Sept 1954		19b. MAJOR FINDINGS OF OPERATION Cx Breast				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) _____		21f. HOW DID INJURY OCCUR? 170X	
21d. TIME OF INJURY (Month) _____ (Day) _____ (Year) _____ (Hour) _____ (Minute) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I hereby certify that I attended the deceased from Sept 1954 , to Oct 1954 , that I last saw the deceased alive on 10/18 , 19 54 , and that death occurred at 11:30 A.M. , from the causes and on the date stated above.			
23a. SIGNATURE Thos. Wash (Degree or title) M.D.		23b. ADDRESS 634 No Grand		23c. DATE SIGNED 10/19			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Oct. 20, 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. OCT 19 1954		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Kriegshauser ADDRESS 4228 S. Kingshighway Bl.			

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 *Richard W. Stoverson*.....

Licensed Embalmer No. 400

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