

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35391

FILED OCT 26 1954

State File No. ....

BIRTH NO. ....		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>9452</b>		
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Warren</b>				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Mo.</b>		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN <b>Charrette</b>		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 <b>BARNES HOSPITAL</b>				STREET ADDRESS (If rural, give location) <b>Rural</b>				
3. NAME OF DECEASED (Type or Print) a. (First) <b>Frances</b>		b. (Middle) <b>Mathilda</b>		c. (Last) <b>Glosemeyer</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Oct. 16, 1954</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH: <b>March 31, 1908</b>		
				9. AGE (In years last birthday) <b>46</b>		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			11. BIRTHPLACE (City and State or Foreign Country) <b>Missouri</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			13a. FATHER'S NAME <b>Martin Kopman</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Struckhoff</b>		14. NAME OF HUSBAND OR WIFE <b>Anthony</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Anthony Glosemeyer, Marthasville, Mo.</b>				
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) <b>Generalized Carcinomatosis (primary site uterus - suspected)</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) 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 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? <b>174X</b>				
22. I hereby certify that I attended the deceased from <b>Sept. 27, 1954</b> , to <b>Oct. 16, 1954</b> , that I last saw the deceased alive on <b>Oct. 16, 1954</b> , and that death occurred at <b>9:25P m.</b> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <b>[Signature] M. D.</b>				23b. ADDRESS <b>BARNES HOSPITAL</b>		23c. DATE SIGNED <b>10/17/54</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>10-17-54</b>		24c. NAME OF CEMETERY OR CREMATORY <b>St. Ignatius Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Concord Hill, Mo.</b>		
DATE REC'D BY LOCAL REG. <b>OCT 18 1954</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Albert H. Hoppe, 4700 Washington Blvd.</b>				

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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 *John J. Kaine*

Licensed Embalmer No. *410*

P. O. Address *B. Lawrence*

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.