

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35955

State File No. \_\_\_\_\_  
Registrar's No. **86511**

FILED OCT 26 1954

REG. DIST. NO. **318**

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

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. CITY OR TOWN <b>ST. LOUIS</b>		c. CITY OR TOWN <b>ST. LOUIS</b>	
c. LENGTH OF STAY (In this place) <b>LIFE</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>CHRISTIAN-HOSPITAL</b>		e. STREET ADDRESS (If rural, give location) <b>3727 A CARTER-AV. 209 1/2</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>FRANCES</b> b. (Middle) <b>C.</b> c. (Last) <b>SEWELL</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>SEPT. 20TH 1954</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>MAY. 9TH 1903</b>
9. AGE (In years last birthday) <b>51 YRS.</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SUPERVISOR</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>ST. LOUIS - MISSOURI</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
10b. KIND OF BUSINESS OR INDUSTRY <b>AUTO-CLUB-OF-MO.</b>	13a. FATHER'S NAME <b>WILLIAM T. LOUIS</b>	13b. MOTHER'S MAIDEN NAME <b>CATHERINE BUNTE</b>	14. NAME OF HUSBAND OR WIFE <b>JOHN W. SEWELL (DECD)</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT'S SIGNATURE, OR NAME AND ADDRESS <b>Dr. H. E. ... 3727 Carter Ave</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <b>MEDICAL CERTIFICATION</b> I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Bilateral ovarian carcinoma</b> INTERVAL BETWEEN ONSET AND DEATH <b>over 8 weeks</b> *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. 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.			
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>175X</b>	
22. I hereby certify that I attended the deceased from <b>Aug. 9, 1954</b> , to <b>Sept 20, 1954</b> , that I last saw the deceased alive on <b>Sept 19, 1954</b> , and that death occurred at <b>9:00 A m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>[Signature]</b> (Degree or title)		23b. ADDRESS <b>4110 West Florissant Ave.</b>	23c. DATE SIGNED <b>Sept 21, 1954</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24b. DATE <b>SEPT. 23 - 1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>CALVARY-CEMETERY.</b>	24d. LOCATION (City, town, or county) (State) <b>ST. LOUIS MO.</b>
DATE REC'D BY LOCAL REG. <b>SEP 22 1954</b>	REGISTRAR'S SIGNATURE <b>[Signature]</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Brockland Und. Co. 1827-HOGAN-ST.</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 *James B. Tuttle*  
Licensed Embalmer No. *36*  
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.