

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **13121**  
**3623**  
Registrar's No.

FILED MAY 13 1955

BIRTH NO. \_\_\_\_\_ 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 (If outside corporate limits, write RURAL and give OR TOWN <b>St. Louis, Mo.</b> )		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN <b>St. Louis</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>BARNES HOSPITAL</b>			e. STREET ADDRESS (If rural, give location) <b>5582 Pershing Ave;</b> <b>2129</b>		
3. NAME OF DECEASED (Type or Print) a. (First) <b>Isabelle</b>		b. (Middle) <b>Heard</b>	c. (Last) <b>Bland</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>April 22, 1955</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>Aug. 24, 1884</b>	9. AGE (In years last birthday) <b>70</b>	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>McLeansboro, Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>Silas Wright Heard.</b>		13b. MOTHER'S MAIDEN NAME <b>Anna Allen Harris.</b>		14. NAME OF HUSBAND OR WIFE <b>Charles P. Bland.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>	16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Wm. W. Green. 538 Locust Court,</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)	MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH <b>9 yrs.</b>
i. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of right breast with metastases to lung, brain, &amp; spine</b>	ANTECEDENT CAUSES <b>with metastases to lung, brain, &amp; spine</b>				
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.	DUE TO (b) <b>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</b>				
	DUE TO (c)				
ii. OTHER SIGNIFICANT CONDITIONS <b>Conditions contributing to the death but not related to the disease or condition causing death.</b>					
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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>170X</b>			
22. I hereby certify that I attended the deceased from <b>April 5, 1955</b> , to <b>April 22, 1955</b> , that I last saw the deceased alive on <b>April 22, 1955</b> , and that death occurred at <b>11:30A</b> from the causes and on the date stated above.					
23a. SIGNATURE <b>J. Carl Smith M.D.</b>			23b. ADDRESS <b>BARNES HOSPITAL</b>		23c. DATE SIGNED <b>4/22/55</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>4/25/1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Missouri</b>		
DATE REC'D BY LOCAL REG. <b>APR 23 1955</b>	REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>C.R. Lupton &amp; Sons; 7233 Delmar Blvd.,</b>			

S.P. (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADEING 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 *Arnold W. Schoene*

Licensed Embalmer No. *3863*

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.