Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 16 1956

36145
STATE FILE NUMBER 9462

Registration District No. 318 Primary Registration District No. 1003 Registrar's No.

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, give TOWNSHIP only) OR TOWN St Louis Mo — Inside Limits Yes ☐ No ☐	c. CITY OR TOWN St Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) St John Hospital — Length of stay in 1b 2 7	d. STREET ADDRESS (If outside, give location) 5638 Mimika — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print)	First: Florence	Middle: Marie	Last: Schmalzer	4. DATE OF DEATH Month Day Year: 10/16/56
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH: 8/18/1915	9. AGE (In years last birthday): 41 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk	10b. KIND OF BUSINESS OR INDUSTRY: Friendly Cleaners	11. BIRTHPLACE (City and state or country): St Louis Mo	12. CITIZEN OF WHAT COUNTRY? Yes	
13. FATHER'S NAME: Sylvester Craden		14. MOTHER'S MAIDEN NAME: Laura Goldsmith		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT: Charles Schmalzer	Address: 5638 Mimika ave	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) General Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: about 6 mo

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b) Adenocarcinoma of rectum — about 12 mo

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

154X

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 12-23-55, to 10-15-56 and last saw her alive on 10-15-56

Death occurred at 3:15 a. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): B D Loughlin M.D.	22b. ADDRESS: 508 N Grand Ave	22c. DATE SIGNED: 10/16/56

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Oct 19/56	23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery	23d. LOCATION (City, town, or county) (State): St Louis Mo

24. FUNERAL DIRECTOR — ADDRESS: JOHN STYGAR & SON — 5541 RIVERVIEW BLVD.	25. DATE RECD. BY LOCAL REG.: OCT 17 1956	26. REGISTRAR'S SIGNATURE: J Carl Smith MD MJB

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

...coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed J M Ristu

Licensed Embalmer No. 390

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (
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.