

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43666

STATE FILE NUMBER

FILED DEC 20 1956

318

1003

10977

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

00 56
 diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

| | | | | | |
|--|----------------------------------|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN University City 1 | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Deaconess Hospital | | Length of stay in 1b | d. STREET ADDRESS 8620 Orchard Ct. | | (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Elsie Middle M. Last Perryman | | | 4. DATE OF DEATH Month Nov. Day 30, Year 1956 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 16, 1903 | 9. AGE (In years last birthday) 52 | IF UNDER 1 YEAR Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY At Home | 11. BIRTHPLACE (City and state or country) Kimmswick, Mo. | | 12. CITIZEN OF WHAT COUNTRY? U.S. |
| 13. FATHER'S NAME Arthur Meyer | | | 14. MOTHER'S MAIDEN NAME Julia Schoeing | | |
| 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. None | 17. INFORMANT Address Robert Perryman, 8620 Orchard Ct. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tumor of brain, metastatic, rt. parietal lobe | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 mos. ? |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | | | | | Left 18 yrs Rt. 1 yr. |
| DUE TO (b) Carcinoma of breast, primary | | | | | |
| DUE TO (c) _____ | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Metastatic carcinoma of lung | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | 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. | | | | | |
| 20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 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 October 1955 to Date and last saw her him alive on 11-29-56 Death occurred at 3:00 a m on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE (Degree or title) Charles S. Sherwin M.D. | | | 22b. ADDRESS 3720 Washington Blvd. | | 22c. DATE SIGNED 11-30-56 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 23b. DATE 12-3-56 | 23c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery | | 23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo. |
| 24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, 4700 Washington Blvd. | | 25. DATE RECD. BY LOCAL REG. NOV 30 1956 | | 26. REGISTRAR'S SIGNATURE Carl Smith MO | |

(Licensed Embalmer's Statement on Reverse Side)

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..... *Robert M. Murray*

Licensed Embalmer No. *3*

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.