

Health, Welfare, Public Service

300-56

diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. X-ray, autopsy, or other information which may be of assistance. X-ray, autopsy, or other information which may be of assistance. X-ray, autopsy, or other information which may be of assistance.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUN 20 1957

318

1003

57 0 2 28 22
STATE FILE NUMBER
5491

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY <input checked="" type="checkbox"/>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS MO</i> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <i>ST. LOUIS</i> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>ST. ANTHONY HOSPITAL</i> Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <i>223 2630 ARMAND PL</i> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>CECILIA F. REISS</i> First Middle Last		4. DATE OF DEATH <i>JUNE 10 1957</i> Month Day Year	
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 21 1897</i>
9. AGE (In years last birthday) <i>59</i>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>OFFICE CLERK</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>LACLEDE GAS</i>	11. BIRTHPLACE (City and state or country) <i>Missouri</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>JOSEPH ZIEROFF</i>	
14. MOTHER'S MAIDEN NAME <i>MARGARET HARTUNG</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>CLEM ZIEROFF 5241 ALABAMA</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma, left breast with</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } - DUE TO (b) <i>metastases to lung and brain</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>8 Mo.</i>
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 <input type="checkbox"/> NO <input checked="" type="checkbox"/> <i>2</i>
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. Month, Day, Year p. m.		20d. INJURY OCCURRED WHILE AT WORK <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 <i>Oct 1949</i> to <i>June 10 1957</i> and last saw her <i>alive</i> on <i>June 10 1957</i> Death occurred at <i>10 PM</i> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Carl Hoffmann M.D.</i> (Degree, or title)		22b. ADDRESS <i>16 Hampton Village Plaza</i>	
22c. DATE SIGNED <i>6/11/57</i>		23a. BURIAL, CREMATION, REMOVAL (Specify)	
23b. DATE <i>JUNE 13 1957</i>		23c. NAME OF CEMETERY OR CREMATORY <i>S.S. PETER & PAUL CEM.</i>	
23d. LOCATION (City, town, of county) (State) <i>ST. LOUIS MO</i>		24. FUNERAL DIRECTOR <i>Thomas Kuter 2906 Leavitt</i> ADDRESS	
25. DATE RECD. BY LOCAL REG. <i>JUN 12 '57</i>		26. REGISTRAR'S SIGNATURE <i>Carl Smith MO</i>	

(Licensed Embalmer's Statement on Reverse Side)

mgs

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.....
Leif Budde
Licensed Embalmer No. 39

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.