FILED AUG 1 - 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26326
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6666

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Inside Limits Yes X No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 08 Deaconess Hosp. — Length of stay in lb 7 Weeks

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY St. Louis
c. CITY OR TOWN Webster Groves 46170 — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 27 584 E. Swon — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First MARJORIE Middle LUCAS Last
4. DATE OF DEATH Month Day Year 7-16-1957

5. SEX F
6. COLOR OR RACE W
7. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 6-23-1893
9. AGE (In years last birthday) 64 — 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) Housewife
10b. KIND OF BUSINESS OR INDUSTRY At home
11. BIRTHPLACE (City and state or country) Keokuk Iowa
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME James Frazer
14. MOTHER'S MAIDEN NAME Unknown

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. None
17. INFORMANT Address R.C. Lucas 584 E. Swon

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) Cardiac Arythmia (Postoperatively) — INTERVAL BETWEEN ONSET AND DEATH 6 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Anemia, Malnutrion, Avitaminosis. — 3 Month
DUE TO (c) Multiple Polyposis of Sigmoid Colon. — 2 Month
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Adrenal insufficiency.
19. WAS AUTOPSY PERFORMED? YES ☐ NO X

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 211 X
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
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 June - 2 - 1957 to July 16 - 57 and last saw her alive on July 15, 1957
Death occurred at 7:30 AM m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Grant Immihan
22b. ADDRESS 731 E. Big Bend Webster (Groves) Mo
22c. DATE SIGNED 7-16-57

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal
23b. DATE 7-18-1957
23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery
23d. LOCATION (City, town, or county) (State) Kirkwood Mo.

24. FUNERAL DIRECTOR ADDRESS Parker-Aldrich Webster Groves Mo.
25. DATE RECD. BY LOCAL REG. JUL 17 57
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

STATEMENT BY LICENSED EMBALMER

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

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

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Leslie Walsh.....

Licensed Embalmer No. 4-3

P. O. Address Webster, Ma

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.