

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-027263

STATE FILE NUMBER

7349

FILED AUG 1 1958

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 Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. John's Hosp		Length of stay in lb 5 days	
3. NAME OF DECEASED (Type or print) First MIDDLE Last LELA MORRISON		4. DATE OF DEATH Month Day Year 7-25-58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-31-1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) hotel operator		10b. KIND OF BUSINESS OR INDUSTRY hotel	9. AGE (In years last birthday) 58
11. BIRTHPLACE (City and state or country) Newburg, Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Fred Hudgens		14. MOTHER'S MAIDEN NAME Martha Ann Alexander	
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. 497-20-6996	
17. INFORMANT Jos. Fiordimondo, St. Louis, Mo.		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) CARCINOMA OF BREAST 170X Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 3 yrs.
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 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 Month, Day, Year a. m. 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 July 1957 to July 25/58 and last saw her alive on 7/25/58. Death occurred at 8:00 PM m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) I. Hansen M.D.		22b. ADDRESS 7820 Coonroad	22c. DATE SIGNED 7/27/58
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 7-28-58	23c. NAME OF CEMETERY OR CREMATORY St. Matthews Cem.	23d. LOCATION (City, town, or county) St. Louis, Mo. (State)
24. FUNERAL DIRECTOR ADDRESS Aker, 4104 Manchester ave.		25. DATE RECD. BY LOCAL REG. JUL 28 1958	26. REGISTRAR'S SIGNATURE Carl Smith MD

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.....  
*Harvey Kahle*

Licensed Embalmer No. 45

P. O. Address Florida

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.