Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

58-042335
STATE FILE NUMBER

FILED DEC 9 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 11289

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 Saint Louis — Inside Limits Yes [X] No [ ]	c. CITY OR TOWN Saint Louis — Inside Limits Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location) 01 4869 Anderson Ave. — Length of stay in lb Life	d. STREET ADDRESS (If outside, give location) 4869 Anderson Ave. — Reside on Farm Yes [ ] No [X]

3. NAME OF DECEASED (Type or print)	First Caroline	Middle Katherine	Last Sydnor	4. DATE OF DEATH	Month Nov. Day 23 Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]	8. DATE OF BIRTH Feb. 15,1867	9. AGE (In years last birthday) 91 yrs	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) Housework	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? USA		
13a. FATHER'S NAME Jacob Kuphfer	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Late Charles H.Sydnor			
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 Mr.John T.Sydnor	Address 4869 Anderson 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) Carcinoma of Rt Parotid gland — INTERVAL BETWEEN ONSET AND DEATH 3 yrs

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

DUE TO (c) 142.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Infirmities of Age

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [X] 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

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 1948, to Nov 23 1958 and last saw her/him alive on Nov 21st 1958

Death occurred at 1 P. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Dr. C. H. Lindeman MD	22b. ADDRESS 4126 Shrew	22c. DATE SIGNED 11/24/58
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11/26/58	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery
23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri		
24. FUNERAL DIRECTOR ADDRESS CALVIN F.FEUTZ, 4828 NAT'L.BRIDGE BLVD.	25. DATE RECD. BY LOCAL REG. NOV 24 '58	26. REGISTRAR'S SIGNATURE J Earl Smith MD MJB

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

4126a Shreve Ave.

10-2 and 4-7

File in city

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 Ralph C. Lindner

Licensed Embalmer No. 4275

P. O. Address St. Louis, N

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