

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011482
State File No.

MAR 30 1959

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar **2 2546**

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, write RURAL and give OR TOWN St. Louis)		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN Pagedale, Mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION De Paul Hospital		e. STREET ADDRESS (If rural, give location) 7925 Alert Drive	

3. NAME OF DECEASED (Type or Print) Margaret Wallhermfechtel			4. DATE OF DEATH (Month) (Day) (Year) March 12, 1959		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH May 30, 1907	9. AGE (In years last birthday) 51	IF UNDER 1 YEAR Months IF UNDER 1 HR. Hour Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME John Quinn	13b. MOTHER'S MAIDEN NAME Margaret Keough	14. NAME OF HUSBAND OR WIFE Adrian
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.	17. INFORMANT'S SIGNATURE OR NAME Adrian Wallhermfechtel
		ADDRESS 7925 Alert Dr.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Metastases		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) from Carcinoma of Breast. DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 170x			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION Biopsy of tibia revealed metastatic Ca	20. AUTOPSY? 2 YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **1/3**, 19**57**, to **3/12**, 19**59**, that I last saw the deceased alive on **3/11**, 19**59**, and that death occurred at **3 AM** m., from the causes and on the date stated above.

23a. SIGNATURE George A. Carver M.D.	(Degree or title)	23b. ADDRESS 607 N. Grand	23c. DATE SIGNED 3/12/59
24a. BURIAL OR CREMATION REMOVAL (Specify) Burial	24b. DATE 3/16/1959	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri

DATE REC'D BY LOCAL REG. MAR 12 '59	REGISTRAR'S SIGNATURE Loard Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Morrell Mortuary	ADDRESS 3710 North Grand
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 *Loren E. Percy*

Licensed Embalmer No. *4094*

P. O. Address *St. Louis,*

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.