

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015362

STATE FILE NUMBER
2-3194

FILED APR 20 1959 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)	
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 Missouri Baptist Hospital		d. STREET ADDRESS (If outside, give location) 2618 a Nebraska ave.	

3. NAME OF DECEASED (Type or print) First Helen Middle D. Last McFail	4. DATE OF DEATH Month March Day 30 Year 1959
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 23, 1902	9. AGE (In years last birthday) 56	10. UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	11. UNDER 24 HRS. Hours 0 Min.
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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) St. Louis, Missouri.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Oscar Layton	13b. MOTHER'S MAIDEN NAME Mary O'Shea	14. NAME OF HUSBAND OR WIFE Lee E. McFail
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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. None	17. INFORMANT Lee E. McFail Address 2618 a Minnesota ave.
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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 Uterus		INTERVAL BETWEEN ONSET AND DEATH 2 yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) 174X		
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"/>

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.)
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20c. TIME OF INJURY Hour _____ 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
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21. I attended the deceased from 1954 , to Mar 30-59 and last saw her alive on Mar 30-59 . Death occurred at 3.25 a.m. on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE W. S. Brown (Degree or title) M.D.	22b. ADDRESS 3903 Olive	22c. DATE SIGNED 3/31/59
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE April 2, 1959	23c. NAME OF CEMETERY OR CREMATORY Park Lawn Cemetery	23d. LOCATION (City, town, or county) (State) 1600 Lemay Ferry Rd. Lemay, Mo.
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24. FUNERAL DIRECTOR ADDRESS C. Hoffmeister Mortuaries, 7814 S. Broadway	25. DATE RECD. BY LOCAL REG. MAR 31 '59	26. REGISTRAR'S SIGNATURE Roan Smith, M.D.
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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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 *James C. Hoffmann*

Licensed Embalmer No. *3871*

P. O. Address *7814 S. Broad*

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.