

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015481

STATE FILE NUMBER

2 4151

FILED MAY 12 1959 Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Franklin | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN Washington Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL | | Length of stay in lb 8 Days | d. STREET ADDRESS (If outside, give location) 104 E. 6th, St. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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| 3. NAME OF DECEASED (Type or print) First LOUISA Middle NMN Last NARUP | | | 4. DATE OF DEATH Month April Day 28 Year 1959 | | |
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| 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 June 24, 1884 | 9. AGE (In years last birthday) 74 | 10. UNDER 1 YEAR Months _____ Days _____ | 11. UNDER 24 HRS. Hours _____ Min. _____ |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | 10b. KIND OF BUSINESS OR INDUSTRY At Home | 11. BIRTHPLACE (City and state or country) St. Louis, Mo. | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
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| 13a. FATHER'S NAME (Unknown) Meyer | 13b. MOTHER'S MAIDEN NAME Unknown | 14. NAME OF HUSBAND OR WIFE Henry Narup |
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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. Nil. | 17. INFORMANT Unknown | Address Elda Narup, 5611 1/2 Devonshire, 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 the vulva | | INTERVAL BETWEEN ONSET AND DEATH 8 mos. |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 176.0 | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |

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| 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 <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 4/19/59 to 4/28/59 and last saw her ^{her} _{her} alive on 4/28/59 Death occurred at April 28, 1959 at 2:05 a. m on the date stated above; and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE <i>FR Bradley</i> | (Degree or title) M. D. | 22b. ADDRESS BARNES HOSPITAL | 22c. DATE SIGNED 4/28/59 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 23b. DATE 4-30-59 | 23c. NAME OF CEMETERY OR CREMATORY St. Francis Borgia Cemetery | 23d. LOCATION (City, town, or county) (State) Washington, Mo. |
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| 24. FUNERAL DIRECTOR Albert H. Hoppe | ADDRESS 4700 Washington, Blvd. | 25. DATE RECD. BY LOCAL REG. APR 28 '59 | 26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i> |
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Stanley H. Dejean*

Licensed Embalmer No. *4193*
P. O. Address *St. Louis, Mo.*

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.