JRI DIVISION OF HEALTH — STANDARD CERTIFICATE OF DEATH

60-009132

STATE FILE NUMBER

FILED VS MAR 1 0 1960

NDED

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 540

1. PLACE OF DEATH
a. COUNTY: St.Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Kirkwood
Length of stay in 1b: 5 days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: St.Joseph's Hospital
Inside Limits: Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY:
c. CITY OR TOWN: St.Louis
Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location): 6585 Oleatha Ave.
Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Nora Middle: D. Last: Dains
4. DATE OF DEATH: Month: February Day: 16 Year: 1960
5. SEX: Female
6. COLOR OR RACE: White
7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: 10/11/1899
9. AGE (last birthday): 60
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HR: Hours: Min.:
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): Dent Co.,Mo.
12. CITIZEN OF WHAT COUNTRY: U.S.
13a. FATHER'S NAME: John Daniels
13b. MOTHER'S MAIDEN NAME: Elizabeth Biggs
14. NAME OF HUSBAND OR WIFE: Troy Dains
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.: 494-10-0583
17. INFORMANT: Troy Dains, 6585 Oleatha Ave.
Address:

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 breast c̄ metastases
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 170 X
INTERVAL BETWEEN ONSET AND DEATH:
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☒ No ☐ Unknown
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ 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 1953 to 2/16/60 and last saw her ~~him~~ alive on 2/16/60
Death occurred at 2.45 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Natajean B. Kappesser M.D.
22b. ADDRESS: 3284 Ivanhoe St Louis
22c. DATE SIGNED: 2/17/60

BY AFFIDAVIT OF

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 2-19-60
23c. NAME OF CEMETERY OR CREMATORY: Ava Evergreen Cemetery
23d. LOCATION (City, town, or county) (State): Ava, Ill.
24. FUNERAL DIRECTOR: Hoener Funeral Home, Cuba, Mo.
ADDRESS:
25. DATE RECD. BY LOCAL REG.: 2-17-60
26. REGISTRAR'S SIGNATURE: John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed Clarence M. Bill

Signature of Student Embalmer

Licensed Embalmer No. 4375

P. O. Address St. Louis 23, M

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