

OCT 14 1939 791

State File No. _____

Registration District No. 1000

Primary Registration District No. _____

Registrar's No. 8161

1. PLACE OF DEATH:

- (a) County 1
(b) City or town ST. LOUIS, MISSOURI
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: BARNES HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 30 days
(Specify whether
In this community 30 da.
years, months or days)

3. (a) PRINT FULL NAME DANIELS, FLORA, BALLARD. 4633. (b) If veteran, nil name war _____ 3. (c) Social Security No. 224. Sex female 5. Color or race White 6. (a) Single, widowed, married, divorced widowed6. (b) Name of husband or wife Flaming S. 6. (c) Age of husband or wife if alive _____ years7. Birth date of deceased Aug 16 1878
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day
61 1 6 _____ hr. _____ min.9. Birthplace Iowa
(City, town, or county) (State or foreign country)10. Usual occupation School Teacher

11. Industry or business _____

12. Name Dr. W. W. Wauson13. Birthplace W. Virg.
(City, town, or county) (State or foreign country)14. Maiden name Wesley P. Daniels15. Birthplace Illinois
(City, town, or county) (State or foreign country)16. (a) Informant's own signature F. Ballard(b) Address Boston Mall17. (a) Cremation (b) Date thereof 9 22 39
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Valhalla18. (a) Signature of funeral director Y. Miller Jones(b) Address Trudell19. (a) _____ (b) J. J. Braddock
(Date received local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State ILLINOIS (b) County _____
(c) City or town Jerseyville **NR**
(If outside city or town limits, write "RURAL")
(d) Street No. 108 NORTH LAFAYETTE
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 22
year 39 hour 4 minute 00 A. M.21. I hereby certify that I attended the deceased from 9
18-, 1939, to 9-22-, 1939;
that I last saw her alive on 9-22-, 1939;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Brain tumor, malignantDue to Metastatic carcinoma of breast

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)Major findings: Malignant brain tumorOf operations left cerebral hemisphereOf autopsy Metastases in anterior medi-
sternum

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (a) Means of injury _____

23. Signature Henry G. Schwartz MD (M. D. or other) _____Address BARNES HOSPITAL Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically

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.....

..... Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, above space should be left blank.