No. 300
10.48

FILED MAY 5 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14043

State File No. 3729

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Homer G Phillips Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: 0 12
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
d. STREET ADDRESS (If rural, give location): 1541 Cole Street

3. NAME OF DECEASED (Type or Print)
a. (First): Nancy
b. (Middle):
c. (Last): Osborne

4. DATE OF DEATH (Month) April (Day) 22 (Year) 1949

5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: 2-11-1871
9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): nil
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): South Carolina
12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: Faint ?
13b. MOTHER'S MAIDEN NAME: Lizzie Nolan
14. NAME OF HUSBAND OR WIFE:

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.:
17. INFORMANT'S SIGNATURE OR NAME: Mable Reed — ADDRESS: 1541 Cole St.

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Rt Breast with Metastases — INTERVAL BETWEEN ONSET AND DEATH: Unk

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

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): 50

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: 170 X

22. *I hereby certify that I attended the deceased from* April 2, 1949, *to* April 22, 1949, *that I last saw the deceased alive on* April 22, 1949, *and that death occurred at* 7:00 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C. R. Frazer M.D.
23b. ADDRESS: 2601 N Whittier Street
23c. DATE SIGNED: 4-25-49

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 4-27-49
24c. NAME OF CEMETERY OR CREMATORY: St. Peter's Cemetery
24d. LOCATION (City, town, or county) (State): St. Louism Mo.

DATE REC'D BY LOCAL REGISTRAR: APR 26 1949
REGISTRAR'S SIGNATURE: J. B. Lasater
25. FUNERAL DIRECTOR'S SIGNATURE: Russell Und., Co. — ADDRESS: 2732 Pine Blvd.

(Licensed Embalmer's Statement on Reverse Side)

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 .....
Student Embalmer

Signed Clark Manning

Licensed Embalmer No. 3371

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 this body is not embalmed, fact should be so stated above.