

FILED JUL 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 20654

BIRTH NO. _____ REG. DIST. NO. 306 PRIMARY REG. DIST. NO. 6048 Registrar's No. 14

1. PLACE OF DEATH a. COUNTY ST. CHARLES		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY 020	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN O'FALLON RURAL		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1		d. STREET ADDRESS (If rural, give location) 3450 WYOMING # 1	
3. NAME OF DECEASED a. (First) MARY b. (Middle) ANN c. (Last) CORTES			4. DATE OF DEATH (Month) (Day) (Year) JUNE 30 1949
5. SEX F	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 2	8. DATE OF BIRTH APRIL 3-1871
9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months 2	IF UNDER 1 YEAR Days 27	IF UNDER 1 YEAR Hours + Min. +
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) COTTLEVILLE MO
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME BEN MENNE	
13b. MOTHER'S MAIDEN NAME SCHMIAT		14. NAME OF HUSBAND OR WIFE BEN CORTES DECEASED	
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'S SIGNATURE OR NAME ADDRESS BLANCHE CORTES O'FALLON #
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Degeneration ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma Right Breast. 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 <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 mo.	
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)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from June 13, 1949 , to June 23, 1949 , that I last saw the deceased alive on June 23, 1949 , and that death occurred at 7:45 A.M. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) W.E. Bargesen, D.O.		23b. ADDRESS Wentzville, Mo.	23c. DATE SIGNED 7-2-49
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE JULY 4-49	24c. NAME OF CEMETERY OR CREMATORY ASSUMPTION	24d. LOCATION (City, town, or county) (State) O'FALLON Mo
DATE REC'D BY LOCAL REG. July 4-49	REGISTRAR'S SIGNATURE E.A. Keithley 280	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS E.A. Keithley O'Fallon Mo.	

(Licensed Embalmer's Statement on Reverse Side)

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

District File Number _____
District Health Officer No. 9,
RECEIVED JUL 8 1949

SEP 8 8 1954

JUL 14 1949

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 *E. C. Kelly*

Licensed Embalmer No. 877

P. O. Address Fallow M

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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