

FILED AUG 13 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24748
6774
Registrar's No.

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Firmin Desloge Hosp.		d. STREET ADDRESS (If rural, give location) 2816 S. Grand Bl.	

3. NAME OF DECEASED (Type or Print) a. (First) Nellie b. (Middle) G. c. (Last) Dueckert			4. DATE OF DEATH (Month) (Day) (Year) 8-3-1949		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH Oct. 10, 1884		9. AGE (In years last birthday) 64		10. IF UNDER 1 YEAR Months Days	
11. BIRTHPLACE (State or foreign country) Amelia, Ohio		12. CITIZEN OF WHAT COUNTRY?			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Amelia, Ohio		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME Coffman Moore			13b. MOTHER'S MAIDEN NAME Lena Montjai			14. NAME OF HUSBAND OR WIFE Louis G. Dueckert	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Louis G. Dueckert 3816 S. Grand Bl.			

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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma of breast. DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 4 years	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Breast amputation Oct. 2, 1945				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 170X					

22. I hereby certify that I attended the deceased from 15 Oct, 1947, to 8-3-49, 19, that I last saw the deceased alive on 8-3-49, 19, and that death occurred at 12:40 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Raymond T. Menter, M.D.			23b. ADDRESS 6203 Clayman			23c. DATE SIGNED 8-4-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8-5-1949		24c. NAME OF CEMETERY OR CREMATORY New St. Marcus Cem.		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.	

DATE REC'D BY LOCAL REG. AUG 4 1949		REGISTRAR'S SIGNATURE J. B. Sasater		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Weick Bro. Und. Co. 2201 S. Grand Bl			
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WRITE PLAINLY--USING UNFADING BLACK INK--MAKE A PERMANENT RECORD

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.

Signed James R. Dunn

Signed _____
Student Embalmer

Licensed Embalmer No. 4527

P. O. Address 2201 S. Grand

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.