

FILED SEP 12 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 27949

BIRTH NO.		REG. DIST. NO. 218	PRIMARY REG. DIST. NO. 1002	Registrar's No. 7622
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY		
b. CITY OR TOWN St. Louis		c. CITY OR TOWN St. Louis		
d. FULL NAME OF HOSPITAL OR INSTITUTION Park Lane Hosp. D		d. STREET ADDRESS (If rural, give location) 2-572I Rosa		
3. NAME OF DECEASED (Type or Print) Marie		a. (First) M.	b. (Middle) Cross	c. (Last)
4. DATE OF DEATH 9 I 49		5. SEX F. W.		6. COLOR OR RACE W.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Wid. ✓		8. DATE OF BIRTH 7 17 98		9. AGE (In years last birthday) 51
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. Louis D
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Joseph M. Fell		
13b. MOTHER'S MAIDEN NAME Mary Weiner		14. NAME OF HUSBAND OR WIFE Frank Cross Dec.		
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 Frank Cross Jr. 572I Rosa
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 Bilateral Carcinoma of the Breast with Metastasis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Not known
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		19a. DATE OF OPERATION Aug 31 49		
19b. MAJOR FINDINGS OF OPERATION Carcinoma of both Breasts with Metastasis		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify) No		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		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 Aug 16, 1949, to Sept 1, 1949, that I last saw the deceased alive on Sept 1, 1949 and that death occurred at 11:00 a.m., from the causes and on the date stated above.				
23a. SIGNATURE Dr. W. O. Lescher, M.D.		23b. ADDRESS 3904 Laclede Ave		23c. DATE SIGNED Sept 2 49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 9 3 49		24c. NAME OF CEMETERY OR CREMATORY S.S. Peter Paul
24d. LOCATION (City, town, or county) (State) St. Louis Mo.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wingbermuehle 3819 S. Grand		
DATE REC'D BY LOCAL REG. SEP. 2 1949		REGISTRAR'S SIGNATURE R. B. Lescher		

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 Law M Sisemore

Signed _____
Student Embalmer

Licensed Embalmer No. 4343

P. O. Address St. Louis, Mo

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.