

FILED OCT 6 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **32436**

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>3069</u>		Registrar's No. <u>15097</u>	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u> b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Richmond Heights</u> c. LENGTH OF STAY (in this place) _____ d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Mary's Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY _____ c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u> d. STREET ADDRESS (If rural, give location) <u>4452 Maryland Ave.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Emilie Lucas</u> b. (Middle) <u>Clayes</u> c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 24, 1949</u>				
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W.</u>	8. DATE OF BIRTH <u>Feb. 9, 1871</u>	9. AGE (In years last birthday) <u>78</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>13</u>	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James D. Lucas</u>		13b. MOTHER'S MAIDEN NAME <u>Florence Deaderick</u>		14. NAME OF HUSBAND OR WIFE <u>George Clayes</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Miss Catherine Clayes</u> ADDRESS <u>4452 Maryland Ave.</u>			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>generalized carcinomatosis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>ovarian carcinoma</u> DUE TO (c) _____ 175X 175X				INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
19a. DATE OF OPERATION <u>6/15/49</u>		19b. MAJOR FINDINGS OF OPERATION <u>metastatic throughout abdomen</u>				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)			
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 <u>6/1</u> , 1949, to <u>9/24</u> , 1949, that I last saw the deceased alive on <u>9/24</u> , 1949, and that death occurred at <u>8:45 pm.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Thomas C. Bondaree M.D.</u> (Degree or title)				23b. ADDRESS <u>4660 Maryland</u>		23c. DATE SIGNED <u>9/26/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Sept. 27, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>9-26-49</u>		REGISTRAR'S SIGNATURE <u>Hedbert R. Blanke</u>		FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J. Donnelly</u> ADDRESS <u>2840 Lindell Blvd.</u>			

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

19-A

OCT 28 1959

APR 17 1950

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

working under my personal supervision.

Student Embalmer No. _____

Student
Student Embalmer

Signed _____

W. Van Matre

Licensed Embalmer No. 2825

P. O. Address 4340 Lafayette

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

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