

FILED DEC 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39284

State File No. _____

#104502

REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10422**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give town OR TOWN) St. Louis, Mo.		a. STATE Missouri b. COUNTY	
c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.		d. STREET ADDRESS (If rural, give location) 10919 Riverview	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year)	
a. (First) MILDRED		b. (Middle) SHAW	
c. (Last)		5. SEX Female	
6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH Feb 22, 1915		9. AGE (In years last birthday) 34	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Granite City, Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Warren Wilson		13b. MOTHER'S MAIDEN NAME Anna Martin	
14. NAME OF HUSBAND OR WIFE Frederick Shaw		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. Nil		17. INFORMANT'S SIGNATURE OR NAME Frederick Shaw-10919 Riverview	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		19. INTERVAL BETWEEN ONSET AND DEATH 3+ yrs.	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Adenocarcinoma Left Breast		II. OTHER SIGNIFICANT CONDITIONS	
ANTECEDENT CAUSES		Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. with Generalized Metastasis	
DUE TO (b)		DUE TO (c)	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input 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)		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 10/13/49 , 19___, to 12/2/49 , 19___, that I last saw the deceased alive on 12/2/49 , 19___, and that death occurred at 9:30pm. , from the causes and on the date stated above.	
23a. SIGNATURE W.M. Turner, M.D. (Degree or title)		23b. ADDRESS 1515 Lafayette Ave.,	
23c. DATE SIGNED 12/3/49		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE 12/3/49		24c. NAME OF CEMETERY OR CREMATORY	
24d. LOCATION (City, town, or county) (State) Alton, Illinois		25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe ADDRESS 4700 Washington Blvd	
DATE REC'D BY LOCAL REG. DEC 14 1949		REGISTRAR'S SIGNATURE A. B. Susater	

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

Mace

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 *Robert M Murray*

Licensed Embalmer No. *3749*

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.