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FILED NOV 21 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File # 89653  
Registrar's No. 4324

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 367 PRIMARY REG. DIST. NO. 3070

1. PLACE OF DEATH a. COUNTY <b>ST LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MO</b> b. COUNTY <b>ST LOUIS</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>WEBSTER GROVES</b>	c. LENGTH OF STAY (in this place) <b>60</b>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>WEBSTER GROVES</b>	d. STREET ADDRESS (If rural, give location) <b>1408 S. ROCK HILL RD</b>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>1408 S ROCK HILL RD</b>		d. STREET ADDRESS (If rural, give location) <b>1408 S. ROCK HILL RD</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>MARY</b> b. (Middle) <b>KATHLEEN</b> c. (Last) <b>WYRICK</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Nov 4 1949</b>		
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5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>AUG 10 1932</b>		9. AGE (In years last birthday) <b>17</b>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HR. Hours	IF UNDER 1 HR. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STUDENT</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <b>TUSCUMBIA MO</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
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13a. FATHER'S NAME <b>ORVILLE WYRICK</b>		13b. MOTHER'S MAIDEN NAME <b>GRACE MARTIN</b>		14. NAME OF HUSBAND OR WIFE <b>NONE</b>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <b>O.O. Thyrick</b>		ADDRESS _____	
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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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Osteogenic sarcoma with metastasis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>	
		ANTECEDENT CAUSES DUE TO (b) _____ Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				<b>1/16X</b>	

19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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) _____	
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____	
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22. I hereby certify that I attended the deceased from 6/11/1946, 1946, to 11/4/1949, 1949, that I last saw the deceased alive on 11/4/49, 1949 and that death occurred at 3:30p m., from the causes and on the date stated above.

23a. SIGNATURE <b>Elsworth Webster MD</b> (Degree or title)		23b. ADDRESS <b>204 E. Big Bend</b>		23c. DATE SIGNED <b>11/5/49</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24b. DATE <b>11-7-1949</b>		24c. NAME OF CEMETERY OR CREMATORY <b>IBERIA CEMETERY</b>		24d. LOCATION (City, town, or county) (State): <b>IBERIA MO</b>	
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DATE REC'D BY LOCAL REG. <b>11-5-49</b>		REGISTRAR'S SIGNATURE <b>Herbert R. Dumble</b>		FUNERAL DIRECTOR'S SIGNATURE <b>W. Parker and Co.</b>		ADDRESS <b>Webster Groves Mo</b>	
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(Licensed Embalmer's Statement on Reverse Side)

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

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**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 Leslie Welch  
Licensed Embalmer No. 4395

P. O. Address Holston Grove

**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.