

FILED MAR 2 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 6018  
1356

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. LOUIS</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS</u>		c. LENGTH OF STAY (in this place) <u>35</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>UNIVERSITY CITY</u>		<u>4356</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. LUKES HOSPITAL</u>				d. STREET ADDRESS (If rural, give location) <u>7375 WELLINGTON AVE;</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>FANITA</u>		b. (Middle) <u>POSER</u>		c. (Last) <u>BOSS.</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>FEB. 10, 1950</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>August 26, 1890.</u>	
9. AGE (In years last birthday) <u>59.</u>		IF UNDER 1 YEAR Months _____ Days _____		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 - - - - -		11. BIRTHPLACE (State or foreign country) <u>St. Louis, Missouri.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Henry Poser.</u>		13b. MOTHER'S MAIDEN NAME <u>Frederica Wehmeyer.</u>		14. NAME OF HUSBAND OR WIFE <u>John M. Boss.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no.</u>		16. SOCIAL SECURITY NO. <u>none.</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>John M. Boss, 7375 Wellington 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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma - Ovaries with metastases to liver and peritoneum</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  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 <u>73 months</u>	
19a. DATE OF OPERATION <u>Oct. 6, 1949.</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinomatous intrafascicular Oct. 6, 1949</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) <u>170X</u>			
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>Oct. 3, 1949</u> to <u>Feb. 10, 1950</u> , that I last saw the deceased alive on <u>Feb. 9, 1950</u> , and that death occurred at <u>12:15 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Omair R. Ferdn</u> (Degree or title) <u>M.D.</u>				23b. ADDRESS <u>4957 Maryland, St. Louis Mo</u>		23c. DATE SIGNED <u>2/10/50</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment.</u>		24b. DATE <u>2/13/50.</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Mausoleum.</u>		24d. LOCATION (City, town, or county) (State) <u>7800 St. Charles Rock Rd.,</u>	
DATE REC'D BY LOCAL REC'D <u>FEB 10 1950</u>		REGISTRAR'S SIGNATURE <u>J. B. Foster</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>C.R. Lupton &amp; Sons; 7233 Delmar Blvd.,</u>			

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.

Student .....  
Student Embalmer

Signed Arnold W. Schoene

Licensed Embalmer No. 3864

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.