

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED FEB 17 1950

State File No. **6724**
Registrar's No. **1030**

318

1003

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

| | | | | | | | | | |
|--|-------------------------------|--|--|--|---|---|------------------------------|--|-----------------------|
| BIRTH NO. _____ | | REG. DIST. NO. _____ | | PRIMARY REG. DIST. NO. _____ | | State File No. 6724 | | Registrar's No. 1030 | |
| 1. PLACE OF DEATH a. COUNTY _____ | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE _____ b. COUNTY _____ | | | | | |
| b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN St. Louis, Mo. | | | c. LENGTH OF STAY (in this place) 14 Months | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo. | | | 13. 13 | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION City Infirmary | | | | d. STREET ADDRESS (If rural, give location) 5800 Arsenal St. | | | | | |
| 3. NAME OF DECEASED (Type or Print) Lulu | | a. (First) | | b. (Middle) Schwer | | c. (Last) | | 4. DATE OF DEATH (Month) (Day) (Year) 1-29-50 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Unknown | | 8. DATE OF BIRTH 11-16-1869 | | 9. AGE (In years last birthday) 80 | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | IF UNDER 1 MIN. Hours |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Illinois | | 12. CITIZEN OF WHAT COUNTRY? | | |
| 13a. FATHER'S NAME James Murphy | | | 13b. MOTHER'S MAIDEN NAME Marie Wallace | | | 14. NAME OF HUSBAND OR WIFE unknown | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT'S SIGNATURE OR NAME City Infirmary Records | | | ADDRESS | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) coronary occlusion few minutes | | | | | | | | | |
| *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. | | | | | | | | | |
| ANTECEDENT CAUSES | | | | | | | | | |
| Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. | | | | | | | | | |
| DUE TO (b) primary carcinoma of breast with | | | | | | | | | |
| DUE TO (c) wide metastasis, organic brain | | | | | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS | | | | | | | | | |
| Conditions contributing to the death but not related to the disease or condition causing death. disease | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | | | 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) 170X | | | | | |
| 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? | | | | | |
| 22. I hereby certify that I attended the deceased from 11-16-48 , 19____, to 1-29-50 , 19____, that I last saw the deceased alive on 1-29-50 , 19____, and that death occurred at 11:25 a.m. from the causes and on the date stated above. | | | | | | | | | |
| 23a. SIGNATURE Robert Louis Bowdich M.D. | | | | 23b. ADDRESS 5800 Arsenal St. | | 23c. DATE SIGNED 1-30-50 | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) | | 24b. DATE 2-2-50 | | 24c. NAME OF CEMETERY OR CREMATORY City Crematory | | 24d. LOCATION (City, town, or county) (State) 5800 Arsenal St. St. Louis, Mo | | | |
| DATE RECD BY FEB 1 1950 | | REGISTRAR'S SIGNATURE J B Pusater | | | 25. FUNERAL DIRECTOR'S SIGNATURE J Ryan - 5800 Arsenal | | | | |

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.....

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

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.