

FILED APR 25 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **15114**
Registrar's No. **3559**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis 2239	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital		d. STREET ADDRESS (If rural, give location) 23-1508 N. 7th	

3. NAME OF DECEASED (Type or Print) a. (First) TINY b. (Middle) WHITE c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) MARCH 22, 1950		
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5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) W 2		8. DATE OF BIRTH JULY 2 / 1880		9. AGE (In years last birthday) 69		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of lifetime, if even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY none				11. BIRTHPLACE (State or foreign country) Illinois				12. CITIZEN OF WHAT COUNTRY?			

13a. FATHER'S NAME BEN				13b. MOTHER'S MAIDEN NAME ADDIE HULBERT				14. NAME OF HUSBAND OR WIFE			
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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)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Lillia Jensen (daughter)			
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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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of lung 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. Metastases to hilar and cervical nodes						INTERVAL BETWEEN ONSET AND DEATH 1 yr	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION vertebral						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) 165X	
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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?	
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22. I hereby certify that I attended the deceased from **3/6**, 19**50**, to **3/22**, 19**50**, that I last saw the deceased alive on **3/22**, 19**50**, and that death occurred at **3:30 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE Joseph C. P. Blaudin, M.D.		23b. ADDRESS 1515 Lafayette Ave.,		23c. DATE SIGNED 4/17/50	
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24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE APR 18 1950		24c. NAME OF CEMETERY OR CREMATORY CITY CEMETERY		24d. LOCATION (City, town, or county) (State) St. Louis, Mo	
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DATE REC'D BY LOCAL REG. APR 18 1950		REGISTRAR'S SIGNATURE J. B. Sasser		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. Ryan - 5700 Arsenal	
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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.....

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.