

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6375**
Registrar's No. **1203**

FILED MAR 5 1952

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

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

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) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (In this place)		2.19	
d. FULL NAME OF HOSPITAL OR INSTITUTION 7819 So. Broadway		d. STREET ADDRESS (If rural, give location) 7819 So. Broadway	
3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) A. c. (Last) Faust		4. DATE OF DEATH (Month) (Day) (Year) Feb. 7, 1952	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Sept. 13, 1872
9. AGE (In years last birthday) 79		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Missouri
10a. USUAL OCCUPATION		10b. KIND OF BUSINESS OR INDUSTRY At Home	12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME Peter Gutjahr		13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE
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 Marie Faust, 7819 So. Broadway
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 esophagus ANTECEDENT CAUSES DUE TO (b) Carcinoma of Breast DUE TO (c) Arteriosclerosis II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Carcinoma of left Breast	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) St. Louis Mo	21f. HOW DID INJURY OCCUR? 170X
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
22. I hereby certify that I attended the deceased from 3/22, 1941 , to Feb 7, 1952 , that I last saw the deceased alive on Feb 6, 1952 , and that death occurred at 6:45 am. , from the causes and on the date stated above.			
23a. SIGNATURE May Stubbhoff MD		23b. ADDRESS 512 Olive Place	23c. DATE SIGNED 2/7/52
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Feb. 9, 1952	24c. NAME OF CEMETERY OR CREMATORY Mt. Olive	24d. LOCATION (City, town, or county) (State) Lemay 23, Mo.
DATE REC'D BY LOCAL REG. FEB 7 1952	REGISTRAR'S SIGNATURE J. Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Fendler Und. Col., 7420 Michigan Ave.	

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 Oliver E. Lender

Licensed Embalmer No. 4148

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.