

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18019

State File No.

FILED JUN 6 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **4415**

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2059
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1			d. STREET ADDRESS (If rural, give location) 5 5637 Enright		
3. NAME OF DECEASED (Type or Print) a. (First) LEONA		b. (Middle) Grace	c. (Last) GERBER	4. DATE OF DEATH (Month) (Day) (Year) MAY 10, 1952	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 18, 1898	9. AGE (in years last birthday) 53	IF UNDER 1 YEAR Months
IF UNDER 1 YEAR Days	IF UNDER 1 HR. Hours	IF UNDER 1 HR. Mts.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME Samuel Allen		13b. MOTHER'S MAIDEN NAME Elizabeth Watts		14. NAME OF HUSBAND OR WIFE George	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME ADDRESS George Gerber, 5637 Enright Ave.		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)			MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatosis			DUE TO (b) Carcinoma of breast, left		1 year?
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.			DUE TO (c)		2 1/2 years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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)		
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 170X		
22. I hereby certify that I attended the deceased from 4-18-52 , 19____, to 5-10-52 , 19____, that I last saw the deceased alive on 5-10-52 , 19____, and that death occurred at 12:05Am. , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) Wm Ersele M.D.			23b. ADDRESS 1515 Lafayette Avenue		23c. DATE SIGNED 5-10-52
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 5-13-52	24c. NAME OF CEMETERY OR CREMATORY Mt. Carmel		24d. LOCATION (City, town, or county) (State) Belleville, Ill.	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE MAY 12 1952 Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd			

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 *Albert G. Hopper* _____

Licensed Embalmer No. *2971* _____

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.