

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **34289**
Registrar's No. **9169**

FILED OCT 15 1953

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BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No. 34289		Registrar's No. 9169					
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) 32 days		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>						
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL				e. STREET ADDRESS (If rural, give location) 21 2918 Delmar Blvd.									
3. NAME OF DECEASED (Type or Print) Madeline			a. (First)		b. (Middle)		c. (Last) Wells		4. DATE OF DEATH (Month) (Day) (Year) September 19, 1953				
5. SEX Female 3		6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married 0		8. DATE OF BIRTH August 28, 1914		9. AGE (In years last birthday) 39		IF UNDER 1 YEAR Months 0	IF UNDER 1 YEAR Days 21	IF UNDER 1 YEAR Hours _____	IF UNDER 1 YEAR Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) Talladega, Alabama /			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13a. FATHER'S NAME Lemon Wells				13b. MOTHER'S MAIDEN NAME Maydelle Hale				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) No				16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Lillie Mae Swope 2918 Delmar Blvd.							
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								INTERVAL BETWEEN ONSET AND DEATH	
				I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Urethral obstruction								3 months	
				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma of cervix								1 1/2 years	
				DUE TO (c) _____									
				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? 171X									
22. I hereby certify that I attended the deceased from 8/18 , 19 53 , to 9/19 , 19 53 , that I last saw the deceased alive on 9/19 , 19 53 , and that death occurred at 2:20Pm. , from the causes and on the date stated above.													
23a. SIGNATURE (Degree or title) FR Bradley 0 M. D.				23b. ADDRESS BARNES HOSPITAL				23c. DATE SIGNED 9/19/53					
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Sept. 23, 1953		24c. NAME OF CEMETERY OR CREMATORY Oak Dale		24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.							
DATE REC'D BY LOCAL REG. SEP 22 1953		REGISTRAR'S SIGNATURE J. Carl Smith M.D.				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. H. RANDLE & SON 3133 Bell Ave.							

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.....
Signature of Student Embalmer

Signed.....
S. J. Peterson

Licensed Embalmer No. *2691*

P. O. Address *2769 Chow*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.