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

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 9 1955

State File No. 12989

BIRTH NO. _____ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 3058 Registrar's No. 108

1. PLACE OF DEATH a. COUNTY St. Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Charles	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Charles		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN O'Fallon, rural, Dardenne 0920	
c. LENGTH OF STAY (in this place) 3 weeks		d. STREET ADDRESS (If rural, give location) 3 mi. no. on St. Paul road	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Joseph Hospital			

3. NAME OF DECEASED (Type or Print)	a. (First) Frances	b. (Middle) Luella	c. (Last) Dames	4. DATE OF DEATH (Month) (Day) (Year) April 29 1955
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5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Jan. 19, 1906	9. AGE (in years last birthday) Months Days # 49 3 10	IF UNDER 1 YEAR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (State or foreign country) Chillicothe, Mo. 0	12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME Fred Albers	13b. MOTHER'S MAIDEN NAME Anna Klein	14. NAME OF HUSBAND OR WIFE Eugene Dames
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If res. give war or dates of service) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Eugene Dames Sr. O'Fallon, Mo.
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 24 DAYS
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic lymphatic Leukemia		
	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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? 2040 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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	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 5 APR 1955 to 29 APR 1955, that I last saw the deceased alive on 29 APR 1955, and that death occurred at 9:45 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Gene J. DeWenter M.D.	23b. ADDRESS O'Fallon, Mo.	23c. DATE SIGNED 2 MAY 55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 5-3-55	24c. NAME OF CEMETERY OR CREMATORY St. Paul Cemetery	24d. LOCATION (City, town, or county) (State) St. Paul, Mo.
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DATE REC'D BY LOCAL REG. May 2 1955	REGISTRAR'S SIGNATURE James Hamilton	FUNERAL DIRECTOR'S SIGNATURE ADDRESS Geo. Steffens St. Peter, Mo.
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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 E. Keithly

Licensed Embalmer No. 822

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.