

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED JUN 22 1955

 BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5069**

1. PLACE OF DEATH a. COUNTY X		2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE Missouri b. COUNTY X	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 5 months	
d. FULL NAME OF HOSPITAL OR INSTITUTION Booth Memorial Hospital		e. STREET ADDRESS (If rural, give location) 24 3740 Marine Avenue	
3. NAME OF DECEASED (Type or Print) a. (First) Rebecca b. (Middle) Rea c. (Last) Preston		4. DATE OF DEATH (Month) (Day) (Year) 6/10/1955	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH 4/18/1906
9. AGE (In years last birthday) 49		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer - Major	11. BIRTHPLACE (State or foreign country) Belfast, Ireland
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Officer - Major		10b. KIND OF BUSINESS OR INDUSTRY The Salvation Army	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME William Preston		13b. MOTHER'S MAIDEN NAME Mary Lewis	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 Mr Elizabeth Johnson ADDRESS 5614 Shaw
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) Cerebral Carcinoma 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 Dec. 1954		19b. MAJOR FINDINGS OF OPERATION Cerebral Carcinoma	
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)	
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? 193X	
22. I hereby certify that I attended the deceased from 12 Jan , 1955, to 10 June , 1955, that I last saw the deceased alive on 10 June , 1955, and that death occurred at 6:30 p.m. , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Chas. Ford M. Seaman		23b. ADDRESS 3740 Marine St. Louis	
23c. DATE SIGNED 10 June 1955			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE June 11, 1955	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Chicago 111.
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE JUN 11 1955	25. FUNERAL DIRECTOR'S SIGNATURE Hoffmeister Colonial Mortuary ADDRESS 6464 Chippewa St., St. Louis, Mo.		

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed.....

Harry J. Schumacher

Licensed Embalmer No. 2679

P. O. Address 7814 S Broadway

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.