

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 25 1956

State File No. **18845**
Registrar's No. **4069**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____		
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 town) St. Louis		c. LENGTH OF STAY (In this place) 6 days		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION Firmin Desloge Hospital				e. STREET ADDRESS (If rural, give location) 4031 Tholozan Avenue <i>2167c</i>				
3. NAME OF DECEASED (Type or Print) a. (First) Louise			b. (Middle) _____		c. (Last) Washford		4. DATE OF DEATH (Month) (Day) (Year) April 22, 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Aug. 16, 1888	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. 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 At Home		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13a. FATHER'S NAME Louis Goetzchain		13b. MOTHER'S MAIDEN NAME Mina Weber		14. NAME OF HUSBAND OR WIFE John Washford				
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. None		17. INFORMANT'S SIGNATURE OR NAME Mrs. Arline Washford ADDRESS 4031 Tholozan				
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) Medullary Carcinoma			INTERVAL BETWEEN ONSET AND DEATH 1 year	
				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.			DUE TO (b) Primary Carcinoma, left Ovary 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 175X				20. AUTOPSY? YES <input 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) _____ m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____				
22. I hereby certify that I attended the deceased from Aug 1955 , to 22 April 1956 , that I last saw the deceased alive on 22 April, 1956 , and that death occurred at 9:55A m., from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) Arch M. Ahern, MD.				23b. ADDRESS 3915 Watson Road		23c. DATE SIGNED 24 April 56		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Apr. 25, 1956	24c. NAME OF CEMETERY OR CREMATORY New St. Marcus Cemetery		24d. LOCATION (City, town, or county) St. Louis, Missouri (State) _____			
DATE REC'D BY LOCAL REG. APR 25 1956		REGISTRAR'S SIGNATURE Carl Smith MD		25. GENERAL DIRECTOR'S SIGNATURE Wacker - Alder		ADDRESS 3634 Gravois Ave.		

(Licensed Embalmer's Statement on Reverse Side)

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

6.300
0.48

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 *Robert C. Wheeler*.....

Licensed Embalmer No. *21*.....

P. O. Address *Levin*.....

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.