

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 6 1956

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28195
State File No. 7198
Registrar's No.

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		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(ship)) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 19		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 St. Anthony Hospital				e. STREET ADDRESS (If rural, give location) 7317a Pennsylvania Avenue			
3. NAME OF DECEASED (Type or Print) a. (First) Norma		b. (Middle) Jeanne		c. (Last) Calvert		4. DATE OF DEATH (Month) (Day) (Year) August 2, 1956	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Jan. 7, 1928	
9. AGE (In years last birthday) 28		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri	
11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME George Thornton		13b. MOTHER'S MAIDEN NAME Katherine	
13a. FATHER'S NAME George Thornton		13b. MOTHER'S MAIDEN NAME Katherine		14. NAME OF HUSBAND OR WIFE Frank		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Frank Calvert		ADDRESS 7317a Pennsylvania, St. Louis	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma Breast ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) metastases DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION 170X		19b. MAJOR FINDINGS OF OPERATION				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 (Month) (Day) (Year) (Hour) (Minute) OF INJURY	
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 (Month) (Day) (Year) (Hour) (Minute) OF INJURY	
21d. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY		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 22 March, 1954 to 8-2, 1956 , that I last saw the deceased alive on 8-2, 1956 and that death occurred at 10:30P.m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Charles A. Nester MD				23b. ADDRESS 5600 S. Compton		23c. DATE SIGNED 8-3-56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Aug. 6, 1956		24c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery		24d. LOCATION (City, town, or county) (State) 1215 Lemay Ferry Road, Lemay, Mo.	
DATE REC'D BY LOCAL REG. Aug 6 1956		REGISTRAR'S SIGNATURE J. Earl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. Hoffmeister U. & L. Co. 7814 So. Broadway 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 Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed. *Price C. Branson*

Licensed Embalmer No. *4764*

P. O. Address *St. Louis,*

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.