

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 16 1956

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9163**

STATE FILE NUMBER

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, give TOWNSHIP only) OR TOWN ST LOUIS		c. CITY OR TOWN ST LOUIS	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION DE PAUL Hosp		Length of stay in lb 7 wks	
		d. STREET ADDRESS 602 1/2 MICHIGAN (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First LELA Middle A Last FAITH			4. DATE OF DEATH Month OCT Day 4 Year 1956		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR-11-1902	9. AGE (In years last birthday) 54 IF UNDER 1 YEAR IF UNDER 24 HRS. Months 6 Days 24 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 (City and state or country) ST LOUIS MO		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME FRANK J. BRUDNER			14. MOTHER'S MAIDEN NAME MINNIE MINEKE		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO NONE		16. SOCIAL SECURITY NO. 487-42-8046	17. INFORMANT Address MRS SHIRLEY McLAUGHLIN 602 1/2 MICHIGAN AV		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Bladder		INTERVAL BETWEEN ONSET AND DEATH 6 mos.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)
		DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Apr 1956 to Oct 4, 1956 and last saw ^{her} _{him} alive on Oct 3, 1956 Death occurred at 5 AM on the date stated above; and to the best of my knowledge, from the causes stated.		
22a. SIGNATURE (Degree or title) M D Johnson M.D.	22b. ADDRESS Ferguson MO	22c. DATE SIGNED 10-6-56

23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE OCT-8-1956	23c. NAME OF CEMETERY OR CREMATORY MISSOURI CREMATORY	23d. LOCATION (City, town, or county) (State) ST LOUIS MO.
24. FUNERAL DIRECTOR FEY FUNERAL HOME	ADDRESS MEHLVILLE MO.	25. DATE RECD. BY LOCAL REG. OCT 8 1956	26. REGISTRAR'S SIGNATURE J. Earl Smith, M.D. <i>J. E. B.</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was by me, ~~or~~ by, Student Embalmer No. working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Elton R. Remel*.....

Licensed Embalmer No. *4*.....

P. O. Address *St. Louis*.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.