

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

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FILED JUL 5 1957

318

1003

STATE FILE NUMBER

Registrar's No. 5880

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

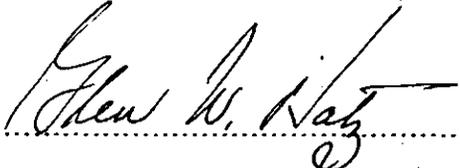
1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Christian Hospital</b>		Length of stay in lb <b>2 Hours</b>	d. STREET ADDRESS <b>4540 Alice Avenue,</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Lena Weber</b>			First	Middle	Last
4. DATE OF DEATH <b>June 22, 1957</b>			Month	Day	Year
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 6, 1898</b>	9. AGE (In years last birthday) <b>59</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Time Keeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>R.C. Cann Co.</b>	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.,</b>
13. FATHER'S NAME <b>Mathew Sofka</b>			14. MOTHER'S MAIDEN NAME <b>Malkan</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>486-16-9309</b>	17. INFORMANT <b>Mr. Joseph D. Weber, 4540 Alice Ave.,</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of Lungs.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					DUE TO (b) <b>Scirrhus Carcinoma of both breasts.</b>
					DUE TO (c) <b>Metastatic Carcinoma of Brain.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Metastatic Carcinoma of Liver</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>
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 <b>5-31-56</b> to <b>6-22-57</b> and last saw her alive on <b>6-22-57</b> Death occurred at <b>7:05 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>Robert C. McQuinn</b> M.D.			22b. ADDRESS <b>4356 Warne Avenue (7)</b>		22c. DATE SIGNED <b>6-24-57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>6-26-1957</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Friedens Cemetery</b>	23d. LOCATION (City, town, or county) <b>St. Louis,</b>	(State) <b>Missouri.</b>	
24. FUNERAL DIRECTOR <b>Math. Hermann &amp; Son Inc. 2161 E. Fair</b>			ADDRESS	25. DATE RECD. BY LOCAL REG. <b>JUN 24 57</b>	26. REGISTRAR'S SIGNATURE <b>J. Carl Smith MD</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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  \_\_\_\_\_

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

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.