

FILED FEB 6 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3263

STATE FILE NUMBER

Registration District No. _____

318

Primary Registration District No. _____

1003

Registrar's No. _____

1078

300

-57

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		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 01 HOSPITAL OR INSTITUTION 4528 Emerson		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 2070 ADDRESS 4528 Emerson
3. NAME OF DECEASED (Type or print) First Middle Last Dora McGrath		4. DATE OF DEATH Month Day Year Jan. 28, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 11, 1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 73
11. BIRTHPLACE (City and state or country) Macon, Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Patrick McGrath		13b. MOTHER'S MAIDEN NAME Dora Metz	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)		16. SOCIAL SECURITY NO.	17. INFORMANT Margaret McGrath 4528 Emerson Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: O.K. IMMEDIATE CAUSE (a) Adenocarcinoma left breast with metastases DUE TO (b) left metastases DUE TO (c) 1/29/58 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 170x			INTERVAL BETWEEN ONSET AND DEATH 18 mo
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 <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 Jan. 1957 to Sept. '57 and last saw her alive on Sept. 26 1957 Death occurred at 7:30 A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Clarence T. Eckert (Degree or title) M.D.		22b. ADDRESS 539 N. Grand Ave	22c. DATE SIGNED 1-28-58
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 1/30/58	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or country) (State) St. Louis, Mo.
24. FUNERAL DIRECTOR Chas. F. Stuart		ADDRESS 1225 Union	25. DATE RECD. BY LOCAL REG. JAN 29 '58
26. REGISTRAR'S SIGNATURE J. Carl Smith mo			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *J. W. B. Bumbley*

Licensed Embalmer No. *3653*

P. O. Address *St. Louis, Mo.*

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.