

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-045448

STATE FILE NUMBER
1003 11494

FILED DEC 22 1958

Registration District No. Primary Registration District No. Registrar's No.

300
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Mo. Baptist Hosp.		d. STREET ADDRESS 6300 Tennessee	
3. NAME OF DECEASED (Type or print) First Middle Last Alice M. Breihan		4. DATE OF DEATH Month Day Year Nov. 28, 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 12, 1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 55
11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles F. Gruet		14. MOTHER'S MAIDEN NAME Margaret Swartz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yrs. give war or dates of service) no none		16. SOCIAL SECURITY NO.	
17. INFORMANT Harry Breihan		Address 6300 Tennessee	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinomatosis Abdomino-thoracis, metastatic</i> DUE TO (b) <i>Carcinoma of ovary left inoperable</i> DUE TO (c) <i>175.0</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>8 mos?</i> <i>15 mos?</i>
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 June 22, 1957, to November 27, 1958. Last saw her alive on 11/27/58. Death occurred at 5:00 a. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>David S. Kieffer M.D.</i>		22b. ADDRESS 100 N. Euclid	22c. DATE SIGNED 11/28/58
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE 12-1-58	23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
24. FUNERAL DIRECTOR Southern Funeral Home 622 S. Grand, S. Louis, Mo.		25. DATE RECD. BY LOCAL REG. NOV 29 1958	26. REGISTRAR'S SIGNATURE <i>Carl Smith M.D.</i>

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Dr Kieffer

100 N Euclid 3 to 5

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. *42*

P. O. Address *51 Lou*

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.