

#40827

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

11551

State File No.

FILED MAY 12 1945

Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 3830

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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County St. Louis, Mo.

(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. Louis City Hospital #1. *H*
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 20 days
(Specify whether

In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 2712 1/2 Heneryetta Ave.
(If rural, give location)

(e) Citizen of foreign country? No. *0* (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME LILLIAN MELL

3. (b) If veteran, name war No 3. (c) Social Security No. NO

4. Sex Female / 5. Color or race White

6. (a) Single, widowed, married, divorced, Widowed

6. (b) Name of husband or wife George Madison 6. (c) Age of husband or wife if alive years

7. Birth date of deceased March 14, 1872
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 29th
year 1945 hour 7:10 minute _____ P. A. M.

21. I hereby certify that I attended the deceased from 4/9/45
to 4/29/45, 19____, to _____, 19____;

that I last saw her alive on 4/29/45, 19____;
and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
<u>73</u>	<u>3</u>	<u>26</u>	hr. _____ min. _____

Immediate cause of death Retrosplenoneal Sarcoma with metastasis *H/O*

Duration _____

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

9. Birthplace Missouri *U*
(City, town, or county) (State or foreign country)

10. Usual occupation House Wife

11. Industry or business _____

12. Name Curran P. Walker

13. Birthplace Missouri *U*
(City, town, or county) (State or foreign country)

14. Maiden name Elizabeth Walden

15. Birthplace Missouri *U*
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Mary Vogel
(b) Address 2712 1/2 Heneryetta Ave.

17. (a) Burial (b) Date thereof 5/2/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Matthews

18. (a) Signature of funeral director G. W. McLaughlin
(b) Address 2-301 Lafayette

19. (a) APR 30 1945 (b) J. F. Bradock
(Date received local registrar) (Registrar's signature)

Major findings:
Of operations _____

Of autopsy Same

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature E. C. Shumaker (M. D. or other) _____
Address 1515 Lafayette Date signed 5/20/45

PHYSICIAN

Underline the cause to which death should be charged statistically.

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.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed: L. R. Cooper

Licensed Embalmer No. 3633

P. O. Address 2317 Lafayette

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 this body is not embalmed, fact should be so stated above.