No. 2
12-45
17-39
X47070

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 9 1947
#3862

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 15324

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4474

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution:
St. Louis City Hospital-Max C. Starkloff
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 17days (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. 3205a So. 9th Memorial
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country

Ward 24 17 90

3. (a) PRINT FULL NAME ELDRIDGE LANCASTER

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex male

5. Color or race white

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

6. (b) Name of husband or wife Mary Lancaster

6. (c) Age of husband or wife if alive years

7. Birth date of deceased — (Month) — (Day) — (Year)

8. AGE: Years abt. 48 | Months — | Days — | If less than one day hr. min.

9. Birthplace Illinois. (City, town, or county) (State or foreign country)

10. Usual occupation Carpenter

11. Industry or business

FATHER
12. Name John Lancaster
13. Birthplace Illinois (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Rebecca Unknown
15. Birthplace Illinois (City, town, or county) (State or foreign country)

16. (a) Informant M. Renard
(b) Address St. Louis City Hospital

17. (a) Anatomical Board (Burial, cremation, or removal) (b) Date thereof 3-18-47 (Month) (Day) (Year)
(c) Place: burial or cremation St. Louis

18. (a) Signature of funeral director W. Kuhlmann
(b) Address 3500 Reuter

19. (a) MAY 2 (Date received local registrar) (b) J. F. Brodeck (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month March day 3rd year 1947 hour 3:20 minute A M.

21. I hereby certify that I attended the deceased from 2/14/47, 19, to 3/3/47, 19; that I last saw him alive on 3/3/47, 19; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Retropeptoneal Sarcoma	1 year
Hemorrhage	2 days
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

23. Signature 1515 Lafayette 3/3/47 (M.D. or other)
Address Date signed

(Licensed Embalmer's Statement on Reverse Side)

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.....

Licensed Embalmer No.....

P. O. Address.....

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.