

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED APR 8 1949

10342  
State File No. 2772  
1003 Registrar's No.

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. _____	
1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Louis</u>		c. LENGTH OF STAY (in this place) _____	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Louis</u>		17 9
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>4801 Austria</u>			d. STREET ADDRESS (If rural, give location) <u>4801 Austria</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>Emily</u>		b. (Middle) <u>Clara</u>	c. (Last) <u>Lyell</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>March 25, 1949</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb 9, 1866</u>	9. AGE (In years last birthday) <u>83</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <u>New Orleans, La.</u>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME _____		13b. MOTHER'S MAIDEN NAME _____		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'S SIGNATURE OR NAME ADDRESS <u>Sregfried Mueller 4801 Austria</u>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of cervix &amp; metastasis</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____  11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Myocardial</u>				INTERVAL BETWEEN ONSET AND DEATH <u>HO</u>
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION <u>141X</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>Jan 21, 1949</u> , to <u>Jan 25, 1949</u> , that I last saw the deceased alive on <u>Jan 24, 1949</u> , and that death occurred at <u>8:20 P. m.</u> , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <u>Benjamin G. Solly M.D.</u>			23b. ADDRESS <u>Mc Hampton Village Plaza</u>		23c. DATE SIGNED <u>3/26/49</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	24b. DATE <u>3/28/49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Summit B. Park</u>	24d. LOCATION (City, town, or county) (State) <u>Jefferson, Mo</u>		
DATE REC'D BY LOCAL REG. <u>MAR 28 1949</u>	REGISTRAR'S SIGNATURE <u>J. B. Foster</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J L Ziegenhein &amp; Sons 7027 Gravois</u>		

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

**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.

Signed Frank J. Owens

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 2245

P. O. Address Hammond

**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.