

FILED MAY 23 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

17881

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 3063 Registrar's No. 916

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Clayton</u> ) c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Clayton</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>7553 Parkdale Ave.</u>		d. STREET ADDRESS (If rural, give location) <u>7553 Parkdale Ave.</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Amelia Lidell</u> b. (Middle) _____ c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>Apr. 14, 1949</u>
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>W.</u>	8. DATE OF BIRTH <u>Apr. 23, 1877</u>
9. AGE (In years last birthday) <u>71</u>		IF UNDER 1 YEAR (Months) (Days) <u>11 21</u>	IF UNDER 24 HRS. (Hours) (Min.) _____
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>Sweden</u>
12. CITIZEN OF WHAT COUNTRY? _____		13a. FATHER'S NAME <u>John Erickson</u>	
13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Harold Lidell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Mabel Lidell</u>		ADDRESS <u>7553 Parkdale</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES	
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <u>4201</u>	
		DUE TO (c) <u>94a</u>	
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
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) (Min.) _____		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>4/14</u> , 19 <u>49</u> , to <u>4/14</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>4/14</u> , 19 <u>49</u> , and that death occurred at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE <u>Donald O. Fish</u> (Degree or title) _____		23b. ADDRESS <u>1634 h. Stone</u>	
23c. DATE SIGNED <u>4/15/49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Apr. 15, 1949</u>	
24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) <u>Boone, Iowa</u>	
DATE REC'D BY LOCAL REG. <u>4/15/49</u>		REGISTRAR'S SIGNATURE <u>Sheldon L. ...</u>	
25. FUNERAL DIRECTOR'S SIGNATURE _____		ADDRESS <u>3840 Lindell Blvd.</u>	

(License and Embalmer's Signature on Reverse Side)

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

96  
2  
3

**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 \_\_\_\_\_ *W H Van Matre*

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

Licensed Embalmer No. *2825*

P. O. Address *4340 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.