

FILED AUG 17 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28896

State File No.

BIRTH NO. _____ REG. DIST. NO. 1812 PRIMARY REG. DIST. NO. 6076 Registrar's No. 1914

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH <u>St. Vincent's Sanitarium</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). | |
| a. COUNTY <u>St. Louis</u> | | a. STATE <u>Mo.</u> | b. COUNTY <u>St. Louis</u> |
| b. CITY (If outside corporate limits, write RURAL and give township) <u>Rural Wellston</u> | | c. CITY (If outside corporate limits, write RURAL and give township) <u>Clayton Mo. 70</u> | |
| c. LENGTH OF STAY (in this place) <u>2 weeks</u> | | d. STREET ADDRESS (If rural, give location) <u>46 Claremont Lane 3</u> | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Vincent's Sanitarium</u> | | | |
| 3. NAME OF DECEASED (Type or Print) | | 4. DATE OF DEATH (Month) (Day) (Year) | |
| a. (First) <u>Mrs. Helen Livingston</u> | | b. (Middle) | |
| c. (Last) | | c. (Last) | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u> | 8. DATE OF BIRTH <u>Jan. 31 - 1906</u> |
| 9. AGE (In years last birthday) <u>43</u> | IF UNDER 1 YEAR Months <u>6</u> Days <u>5</u> | IF UNDER 24 HRS. Hours <u>5</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | 11. BIRTHPLACE (State or foreign country) <u>Cleveland Ohio</u> | 12. CITIZEN OF WHAT COUNTRY? |
| 13a. FATHER'S NAME <u>Piericles D. George</u> | | 13b. MOTHER'S MAIDEN NAME <u>Nellie Mullen</u> | |
| 14. NAME OF HUSBAND OR WIFE <u>Mr. David W. Livingston</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>Mr. David Livingston</u> | | ADDRESS <u>46 Claremont La.</u> | |

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|--|--|---|--|--|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH | |
| 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Subarachnoid Hemorrhage</u> | | ANTECEDENT CAUSES | | <u>1 hr</u> | |
| *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death. | | Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. | | <u>Cardiovascular renal disease 1 yr</u> | |
| DUE TO (b) <u>Cardiovascular renal disease</u> | | DUE TO (c) <u>None</u> | | <u>442X</u> | |
| II. OTHER SIGNIFICANT CONDITIONS | | Conditions contributing to the death but not related to the disease or condition causing death. | | <u>Manic depressive psychosis 2 months</u> | |

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|--|--|--|--|---|--|
| 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 April 19, 1948, to Aug 6, 1949, that I last saw the deceased alive on 8/6, 1949, and that death occurred at 10:15 m., from the causes and on the date stated above.

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|---|--|--|--|-----------------------------------|--|
| 23a. SIGNATURE <u>W B Lyttan M.D.</u> (Degree or title) | | 23b. ADDRESS <u>4967 Maryland Ave</u> | | 23c. DATE SIGNED <u>8/6/49</u> | |
|---|--|--|--|-----------------------------------|--|

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| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 24b. DATE <u>Aug. 10, 1949</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>S.S. Peter & Paul</u> | | 24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u> | |
|--|--|-----------------------------------|--|--|--|--|--|

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| DATE REC'D BY LOCAL REG. <u>8-9-49</u> | | REGISTRAR'S SIGNATURE <u>Helen P. ...</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. ...</u> | | ADDRESS <u>240 Lindell Blvd.</u> | |
|---|--|--|--|--|--|-------------------------------------|--|

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.....

Thomas R. Fenwick

Signed.....

Student Embalmer

Licensed Embalmer No.

3793

P. O. Address.....

3840 Lincoln

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do the above constitutes grounds for revocation of license.)

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