S. No. 300
v. 10.48

FILED SEP 9 1950

STANDARD CERTIFICATE OF DEATH

State File No. 28006

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 7408

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lutheran Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
d. STREET ADDRESS (If rural, give location): 1819 Nebraska

17 2179 0

3. NAME OF DECEASED (Type or Print)
a. (First): Lillie
b. (Middle):
c. (Last): Belew

4. DATE OF DEATH (Month) (Day) (Year): August 29, 1950

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept. 11, 1886
9. AGE (In years last birthday): 63 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY?: U.S.

13a. FATHER'S NAME: Isaac Davis
13b. MOTHER'S MAIDEN NAME: Victoria Davis
14. NAME OF HUSBAND OR WIFE: William

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME — **ADDRESS**: William Belew, 1819 Nebraska

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 10 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Heart disease Decompensation 5 days
DUE TO (c) arteriosclerosis ?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 4500

X

22. *I hereby certify that I attended the deceased from* 27 Aug, 1950, *to* 29 Aug, 1950, *that I last saw the deceased alive on* 29 Aug, 1950, *and that death occurred at* 6 pm., *from the causes and on the date stated above.*

23a. SIGNATURE: V. Dworkin
(Degree or title): MD
23b. ADDRESS: 1657 So Grand
23c. DATE SIGNED: 30 Aug 50

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-2-50
24c. NAME OF CEMETERY OR CREMATORY: Valhalla Cem
24d. LOCATION (City, town, or county) (State): St. Louis, Mo.

DATE REC'D BY LOCAL REG.: AUG 30 1950
REGISTRAR'S SIGNATURE: J. B. Sarater
25. FUNERAL DIRECTOR'S SIGNATURE — **ADDRESS**: Fred M. Williams, 4535 Washington Blvd

(Licensed Embalmer's Statement on Reverse Side)

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~~ .....,

working under my personal supervision.

Student Embalmer No. .....

Signed .....

Licensed Embalmer No. 699

P. O. Address St. Charles, Mo.

Signed .....
Student Embalmer

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.