

FILED JAN 26 1951  
#79088

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH  
318

State File No. 2462  
473  
Registrar's No.

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.		
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY				
b. CITY OR TOWN St. Louis, Missouri		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN St. Louis		2017		
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.				d. STREET ADDRESS (If rural, give location) 4094 Fillmore				
3. NAME OF DECEASED (Type or Print) LILLIAN E. DICKMANN			a. (First) b. (Middle) c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) Jan. 15th, 1951		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, QUITTED (Specify) Married		8. DATE OF BIRTH Aug. 17, 1891		
9. AGE (In years last birthday) 59		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) St. Louis, Missouri		
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME Michael Schuster		13b. MOTHER'S MAIDEN NAME Elizabeth Adams		14. NAME OF HUSBAND OR WIFE William A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT'S SIGNATURE OR NAME William A. Dickmann-4094 Fillmore				
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) <u>Cerebral hemorrhage</u>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Septemic Carditis - vascular disease</u> DUE TO (c)  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 443x					INTERVAL BETWEEN ONSET AND DEATH 5-6 hrs.  ?	
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) (Minute)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? X				
22. I hereby certify that I attended the deceased from <u>12/25/50</u> , to <u>1/15/51</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>1/15/51</u> , 19 <u>51</u> , and that death occurred at <u>5:35pm</u> m., from the causes and on the date stated above.								
23a. SIGNATURE <u>E. J. Schuster, M.D.</u>				23b. ADDRESS 1515 Lafayette Ave.,		23c. DATE SIGNED 1/16/51		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1/19/51		24c. NAME OF CEMETERY OR CREMATORY N. St. Marcus Cem.		24d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri		
DATE REC'D BY LOCAL REG. JAN 17 1951		REGISTRAR'S SIGNATURE J. B. Carter		25. FUNERAL DIRECTOR'S SIGNATURE Wacker - Helderle		ADDRESS 3634 Gravois		

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.

Signed.....  
Student Embalmer

Student Embalmer No. ....

Signed..... *Frank J. Hand*

Licensed Embalmer No. *2675*

P. O. Address *J. Courno*

**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.**