

STANDARD CERTIFICATE OF DEATH

State File No. 31874  
8127

FILED SEP 22 1951

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1002 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 (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2199	
d. FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital		d. STREET ADDRESS (If rural, give location) 17 2940 Park Ave. 0	

3. NAME OF DECEASED (Type or Print) a. (First) Lucille b. (Middle) E. c. (Last) Stafford		4. DATE OF DEATH (Month) (Day) (Year) 9/13/51	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Nov. 25, 1920
9. AGE (In years last birthday) 30		# UNDER 1 YEAR Months	# UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) St. Louis, Missouri U	
10b. KIND OF BUSINESS OR INDUSTRY ---		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME Fred Meier		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Earl	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No ---		16. SOCIAL SECURITY NO. ---		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Earl Stafford--2940 Park Ave.	

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>Eclampsia, FULMINATING</u>		INTERVAL BETWEEN ONSET AND DEATH <u>22 Hrs.</u>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <u>Uremia</u>		<u>21 Hrs.</u>	
		DUE TO (c)			
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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>642.3</u>	

22. I hereby certify that I attended the deceased from 9/12, 1951, to 9/13, 1951, that I last saw the deceased alive on 9/13, 1951, and that death occurred at 4:45 a. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Hugh R. Smith M.D. U</u>		23b. ADDRESS <u>607 N. Grand Blvd</u>		23c. DATE SIGNED <u>9/13/51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial U</u>		24b. DATE <u>9/15/51</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cemetery</u>	
				24d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Missouri</u>	

DATE REC'D BY LOCAL REG. SEP 13 1951		REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Wacker-Helderte 3634 Gravois</u>	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

OCT 30 1960

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.....  
Student Embalmer

Signed *Robert Wheeler*.....

Licensed Embalmer No. *2128*.....

P. O. Address *Lawrence*.....

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.