

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

36584

State File No. _____

FILED NOV 14 1952

318

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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 location: residence before admission). a. STATE Mo.		b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis County	
d. FULL NAME OF HOSPITAL OR INSTITUTION DePaul Hospital		d. STREET ADDRESS 1205 Ashford Drive		Hills Bissel	

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) R. c. (Last) Lolor			4. DATE OF DEATH (Month) (Day) (Year) 10-9-52			
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 10-25-1890	9. AGE (In years last birthday) 61	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) Shop Foreman		10b. KIND OF BUSINESS OR INDUSTRY Pullman Company		11. BIRTHPLACE (City and State or Foreign Country) Denver, Colorado		12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME James Lolar		13b. MOTHER'S MAIDEN NAME Margaret Byrne		14. NAME OF HUSBAND OR WIFE Sarah F. Lolor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME Mrs. Sarah F. Lolor-1205 Ashford Dr.	

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Gastro Intestinal Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Duodenal Diverticulum</u>		
	DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION 10-7-52	19b. MAJOR FINDINGS OF OPERATION Duodenal Diverticulum	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 578X

22. I hereby certify that I attended the deceased from 7-15, 1952, to 10-9, 1952, that I last saw the deceased alive on 10-9, 1952, and that death occurred at 10:30 a.m., from the causes and on the date stated above.

22a. SIGNATURE <u>W. Schupel M.D.</u>	23b. ADDRESS <u>634 No. Grand Blvd.</u>	23c. DATE SIGNED <u>10-9-52</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10-11-52	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. OCT 10 1952	REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur J. Donnelly, 3840 Wendell</u>
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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student

Student Embalmer

Signed _____

W H Van Matre

Licensed Embalmer No. 2825

P. O. Address 3840 Lindell

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.