

FILED DEC 12 1952

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

40650

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State File No. ....

Registrar's No. 10693

BIRTH NO. ....		REG. DIST. NO. ....		PRIMARY REG. DIST. NO. ....		State File No. ....		Registrar's No. ....	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY					
b. CITY (If outside corporate limits, write RURAL and give town) <b>St. Louis, Mo.</b>		c. LENGTH OF STAY (In this place) township)		c. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		2148			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>5210 Fairview</b>				d. STREET ADDRESS (If rural, give location) <b>14 5210 Fairview</b>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>Lucille</b>		b. (Middle) <b>Etta</b>		c. (Last) <b>Richter</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>11 19 52</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>March 10, 1900</b>		9. AGE (In years last birthday) <b>52</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>Hardin Co., Ill.</b>		12. CITIZEN OF WHAT COUNTRY?			
13a. FATHER'S NAME <b>Unknown Ginger</b>			13b. MOTHER'S MAIDEN NAME <b>Unknown</b>			14. NAME OF HUSBAND OR WIFE <b>Clem J.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>334-07-7499</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Clem J. Richter, 5210 Fairview</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of colon with metastases to lung and abdomen</b>  ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last:</i>  DUE TO (b) _____  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i> <b>Multiple polyps of colon</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input 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 <b>153X</b>					
22. I hereby certify that I attended the deceased from <b>August 1950</b> , to <b>11-19 1952</b> , that I last saw the deceased alive on <b>11-19 1952</b> , and that death occurred at <b>11:20 a.m.</b> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <b>C. Barber Mueller M.D.</b>				23b. ADDRESS <b>BARNES HOSPITAL</b>				23c. DATE SIGNED <b>11-19-52</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>11-19-52</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Local</b>		24d. LOCATION (City, town, or county) (State) <b>Rosiclare, Ill.</b>			
DATE REC'D BY LOCAL REG. <b>NOV 20 1952</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Albert H. Hoppe, 4700 Washington Blvd.</b>					

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

*Robert M. Murray*

Licensed Embalmer No. *3749*

P. O. Address *St. Louis, Mo.*

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.