

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **3921**  
Registrar's No. **0282**

FILED JAN 28 1954

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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>ST. LOUIS</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>Jennings #138</b>	
c. LENGTH OF STAY (In this place)		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>DePaul Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>2925 Solway Ave</b>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) <b>Helen</b>	b. (Middle) <b>E.</b>	c. (Last) <b>Lippold</b>	(Month) <b>Jan.</b>	(Day) <b>9</b>	(Year) <b>1954</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>MAR 29 1911</b>	9. AGE (In years last birthday) <b>42</b>	IF UNDER 1 YEAR Months Days
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>Radom, Pll</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>

13a. FATHER'S NAME <b>Dominic Heven dowski</b>	13b. MOTHER'S MAIDEN NAME <b>ANNA Barcerowski</b>	14. NAME OF HUSBAND OR WIFE <b>Lawrence Lippold</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>	16. SOCIAL SECURITY NO. (If yes, give or date of service) <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME. ADDRESS <b>Lawrence Lippold 2925 Solway Ave</b>

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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Carcinoma of Cardia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Pituitary failure</b>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

21a. (Specify) 21a. SUICIDE HOMICIDE	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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>151X</b>

22. I hereby certify that I attended the deceased from **Aug 19 52** to **Jan 9 1954**, that I last saw the deceased alive on **1-9**, 1954, and that death occurred at **12:55 P.M.**, from the causes and on the date stated above.

23a. SIGNATURE <b>E. D. Casindy</b> (Degree or title)	23b. ADDRESS <b>4952 Maryland</b>	23c. DATE SIGNED <b>1-11-54</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>1-13-54</b>	24c. NAME OF CEMETERY OR OREMATORY <b>Calvary Cemetery</b>
		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>

DATE REC'D BY LOCAL REG. <b>JAN 11 1954</b>	REGISTRAR'S SIGNATURE <b>Carl Smith</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Mr. John Stygar &amp; Son 5541 Riverview</b>
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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.....  
Signature of Student Embalmer

Signed.....  
*J. Allen Davis*

Licensed Embalmer No.....  
*4*

P. O. Address.....  
*St. Paul*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.