

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

7340

State File No. _____

BIRTH NO. FILED FEB 18 1954 REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 598 Registrar's No. 287

1. PLACE OF DEATH a. COUNTY St. Louis		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 OR-1 TOWN St. Louis Co - Jennings) c. LENGTH OF STAY (in this place) 15 Days		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION Halls Ferry Nursing Home		d. STREET ADDRESS (If rural, give location) 5579 Pershing	

3. NAME OF DECEASED (Type or Print) a. (First) Alice	b. (Middle) Mary	c. (Last) Lark	4. DATE OF DEATH (Month) (Day) (Year) Feb. 1 1954
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorce	8. DATE OF BIRTH Aug 20 1887
9. AGE (in years last birthday) 66	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress Owner	10b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED	11. BIRTHPLACE (City and State or Foreign Country) New Hanover Ill
12. CITIZEN OF WHAT COUNTRY? USA			

13a. FATHER'S NAME Wm. Lark	13b. MOTHER'S MAIDEN NAME Mary Morath	14. NAME OF HUSBAND OR WIFE DIVORCED
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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. NONE	17. INFORMANT'S SIGNATURE OR NAME Forrest Lark	ADDRESS 950-12th Str. (Care
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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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Unknown
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma, liver		
	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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 1561	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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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?
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22. I hereby certify that I attended the deceased from **Jan 15, 1954** to **Feb 1, 1954**, that I last saw the deceased alive on **Jan 26, 1954**, and that death occurred at **9:55A m.**, from the causes and on the date stated above.

23a. SIGNATURE Lewis Littmann	(Degree or title) M.D.	23b. ADDRESS 8231 Clayton Rd (17)	23c. DATE SIGNED 2/1/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	24b. DATE 2/3/54	24c. NAME OF CEMETERY OR CREMATORY Mo. Crematory	24d. LOCATION (City, town, or county) (State) St. Louis Mo.
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DATE REC'D BY LOCAL REG. 2-1-54	REGISTRAR'S SIGNATURE Wm. Schumacher	25. FUNERAL DIRECTOR'S SIGNATURE Wm. Schumacher	ADDRESS 3013 Meramec
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Not (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

No. 300
10-48

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*Dr. Legemann
8266 Clayton*

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 *Jack Legemann* _____

Licensed Embalmer No. *4746*

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.