

FILED JUL 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

25368

318

1003

Registrar's No. 6241

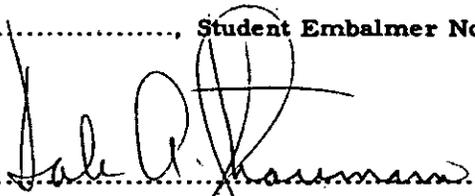
BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <u>St. Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>St. Luke's Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>18 4503 Wichita 21890</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>LILLIAN</u>		b. (Middle) <u>T.</u>		c. (Last) <u>VANDELOECHT</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>July 9 1954</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>		8. DATE OF BIRTH <u>Dec. 30, 1897</u>	
9. AGE (In years last birthday) <u>56</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 2 HRS. Hours _____ Min. _____		11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		12. CITIZEN OF WHAT COUNTRY? <u>0</u>			
13a. FATHER'S NAME <u>Henry Vandeloecht</u>		13b. MOTHER'S MAIDEN NAME <u>Clara Unknown</u>		14. NAME OF HUSBAND OR WIFE _____			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>John W. Burian 4012 Chouteau Ave.</u>			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bilateral papillary carcinoma of ovaries & metastases to lung, liver etc</u> 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. <u>R. hemiplegia due to cerebral hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u> <u>6 wks.</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				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? <u>175X</u>			
22. I hereby certify that I attended the deceased from <u>1946</u> to <u>July 9, 1954</u> , that I last saw the deceased alive on <u>July 8, 1954</u> , and that death occurred at <u>2:00 A.M.</u> from the causes and on the date stated above.							
23a. SIGNATURE (Name or title) <u>George W. Stuer M.D.</u>				23b. ADDRESS <u>3720 Washington Blvd</u>		23c. DATE SIGNED <u>7-9-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>		24b. DATE <u>July 12, 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Mausoleum</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>	
DATE REC'D BY LOCAL REG. <u>JUL 10 1954</u>		REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Kriegshauser 4228 S. Kingshighway Bl.</u>			

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 , Student Embalmer No.

Licensed Embalmer No. 453

P. O. Address

**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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.**