

FILED MAR 31 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

9349

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) <u>St. Louis</u>		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"/>
c. LENGTH OF STAY (in this place) <u>13 wks</u>		STREET ADDRESS (If rural, give location) <u>2029 18 Willmore Rd.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Incarneate Word Hospital</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Christel</u> b. (Middle) c. (Last) <u>Bellew</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 28 1955</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>Sept 28 1920</u>	9. AGE (In years last birthday) <u>34</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>0</u>	IF UNDER 24 HRS. Hour <u></u> Min. <u></u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office worker</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Fairbanks-Morse</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Germany</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
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13a. FATHER'S NAME <u>Chris Lacktrup</u>	13b. MOTHER'S MAIDEN NAME <u>Emma Blank</u>	14. NAME OF HUSBAND OR WIFE <u>--</u>
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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) <u>No</u>	16. SOCIAL SECURITY NUMBER <u>491-14-4193</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Martha Telle 18 Willmore Rd.</u>
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hour</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Ac. dilation of heart</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>Ca of coronary &amp; generalized arteriosclerosis</u>		<u>1/2 hr or more</u>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>175 X</u>
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22. I hereby certify that I attended the deceased from 12-1, 1953, to 2-28, 1955, that I last saw the deceased alive on 2-28, 1955, and that death occurred at 11:30 P.M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Ernest W. Creulius M.D.</u>	23b. ADDRESS <u>752 Leavenworth St.</u>	23c. DATE SIGNED <u>3-2-55</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>Mar 3 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo</u>
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DATE REC'D BY LOCAL REG. <u>MAR 3 1955</u>	REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J.L. Ziegenhein &amp; Sons 7027 Gravois</u>
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WRITE PLAINLY—USING UNFADEING 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 *B. P. Kidwell*

Licensed Embalmer No. *3877*

P. O. Address *7027 Kra*

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.