

FILED APR 28 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13465

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **3380**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN ST LOUIS
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL		STREET ADDRESS (If rural, give location) 23 16 16 S 12th St	
3. NAME OF DECEASED (Type or Print) a. (First) LILLIAN b. (Middle) c. (Last) HOLMAN		4. DATE OF DEATH (Month) (Day) (Year) APRIL 14, 1955	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED	8. DATE OF BIRTH MARCH 10 - 1910
9. AGE (In years last birthday) 45	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK	10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (City and State or Foreign Country) MO
11. BIRTHPLACE (City and State or Foreign Country) MO	12. CITIZEN OF WHAT COUNTRY? U-S-A	13a. FATHER'S NAME IGNATIUS HOLMAN	13b. MOTHER'S MAIDEN NAME MARY MISBAUER
14. NAME OF HUSBAND OR WIFE	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO.	16. SOCIAL SECURITY NO. NONE	17. INFORMANT'S SIGNATURE OR NAME Edward Holman ADDRESS 3231 Pennsylvania
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Embolism ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Adenocarcinoma of uterus + DUE TO (c) Imping of ovary (Right) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Obesity, hypertension	
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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 174X	
22. I hereby certify that I attended the deceased from 4-8-55 , 19___, to 4-14-55 , 19___, that I last saw the deceased alive on 4-14-55 , 19___, and that death occurred at 8:35A m. , from the causes and on the date stated above.			
23a. SIGNATURE Louis E. Jurek, M.D. (Degree or title)		23b. ADDRESS 1515 Lafayette Avenue	23c. DATE SIGNED 4-14-55
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE APRIL-18-1955	24c. NAME OF CEMETERY OR CREMATORY RESURRECTION	24d. LOCATION (City, town, or county) (State) ST LOUIS CO, MO
DATE REC'D BY LOCAL REG. APR 15 1955	REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Thomas Kutis ADDRESS 2906 Gravois	

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..... *James C. Dill*

Licensed Embalmer No. *434*

P. O. Address *2906 G*

- 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.