

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14263

FILED APR 27 1955

State File No.

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 690 Registrar's No. 872

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri		b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give town) Breckenridge		c. LENGTH OF STAY (In this place) 3 Years		c. CITY OR TOWN Breckenridge	
d. FULL NAME OF HOSPITAL OR INSTITUTION 3347 Tennyson Ave.		STREET ADDRESS (If rural, give location) 3347 Tennyson Ave.			

3. NAME OF DECEASED (Type or Print) a. (First) Alna b. (Middle) Lloyd c. (Last) Lingle			4. DATE OF DEATH (Month) (Day) (Year) April 12, 1955		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Aug. 6, 1922		9. AGE (In years last birthday) 32
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY Laclede Gas.		11. BIRTHPLACE (City and State or Foreign Country) Willow Springs, Mo.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME James D. Lingle		13b. MOTHER'S MAIDEN NAME Edith Baldwin		14. NAME OF HUSBAND OR WIFE Clara Lingle	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Navy W.W.11 499-12-1034		17. INFORMANT'S SIGNATURE OR NAME Clara Lingle ADDRESS 3347 Tennyson A. Overland	

18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Undifferentiated Anemia of Lung					1 1/2 yrs
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		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			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 12-31, 1954, to 4-12, 1955, that I last saw the deceased alive on 4-12, 1955, and that death occurred at 7:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Al Noller M.D.		23b. ADDRESS 2438 W. Watson Rd		23c. DATE SIGNED 4/14/55	
24a. BURIAL CREMATION (Specify) Burial		24b. DATE 4/15/55		24c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cem.	
24d. LOCATION (City, town, or county) (State) Pattonville Mo.					

DATE REC'D BY LOCAL REG. 4-15-55		REGISTRAR'S SIGNATURE Robert D. Donkey M.D.		25. GENERAL DIRECTOR'S SIGNATURE ADDRESS Baumann Bros Inc. 504 W. Watson Rd. Overland, Mo.	
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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 *Oscar F. Mueller*.....

Licensed Embalmer No. *303*.....

P. O. Address *Overland*.....

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.