

FILED SEP 13 1955

## STANDARD CERTIFICATE OF DEATH

State File No. 27637

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 7079			
1. PLACE OF DEATH a. COUNTY				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 township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 2 MO.		c. CITY OR TOWN Ferguson #109		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION: DePaul Hospital				e. STREET ADDRESS (If rural, give location) 201 Darst Rd.					
3. NAME OF DECEASED (Type or Print) Lydia			a. (First)		b. (Middle) Lucille		c. (Last) Epperson		
4. DATE OF DEATH (Month) (Day) (Year) Aug. 12, 1955.		5. SEX F.		6. COLOR OR RACE W.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Nov. 29, 1914	
9. AGE (In years last birthday) 40		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.			12. CITIZEN OF WHAT COUNTRY? U. S.			13a. FATHER'S NAME Charles P. Martin		13b. MOTHER'S MAIDEN NAME Lydia Ellerbrock	
14. NAME OF HUSBAND OR WIFE Halstead L. Epperson		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 ADDRESS Halstead L. Epperson, Ferguson, Mo.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Intra cranial aneurysm</i>						INTERVAL BETWEEN ONSET AND DEATH <i>4 hrs ±</i>	
*This does not mean the mode of dying, such as heart failure, asthma, 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. <i>Polycystic 1 adnex</i>									
19a. DATE OF OPERATION <i>7/2/55</i>		19b. MAJOR FINDINGS OF OPERATION <i>Intra Cranial aneurysm - 2/52x</i>						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?					
22. I hereby certify that I attended the deceased from <i>7/13, 1955</i> to <i>8/12, 1955</i> , that I last saw the deceased alive on <i>8/12, 1955</i> , and that death occurred at <i>8:15 A.M.</i> , from the causes and on the date stated above.									
23a. SIGNATURE (Name or title) <i>Edmund A. Duvic M.D.</i>				23b. ADDRESS <i>Beaumont Max Bldg</i>		23c. DATE SIGNED <i>8/12/55</i>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		24b. DATE <i>8/15/55.</i>		24c. NAME OF CEMETERY OR CREMATORY <i>Valhalla Cemetery</i>		24d. LOCATION (City, town, or county) (State) <i>St. Louis County, Mo.</i>			
DATE REC'D BY LOCAL REG. <i>AUG 12 1955</i>		REGISTRAR'S SIGNATURE <i>J. Carl Smith, M.D.</i>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>White Chapel, Ferguson, M.</i>				

G.P. (Licensed Embalmer's Statement on Reverse Side)

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 Eleanor Province

Licensed Embalmer No. 340

P. O. Address Jennings

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.