

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT/7-1955

State File No. **31134**
8644

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY Madison	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo		c. CITY OR TOWN Granite City	
c. LENGTH OF STAY (In this place) 3 mos.		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 St. Louis Children's		e. STREET ADDRESS (If rural, give location) R.R. #2 Box 649 81208	

3. NAME OF DECEASED (Type or Print) a. (First) LINDA b. (Middle) LEIAN c. (Last) LANCE			4. DATE OF DEATH (Month) (Day) (Year) 10 - 1 - 55		
5. SEX F		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	
8. DATE OF BIRTH 7-29-55		9. AGE (In years last birthday) 2		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)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Granite City, Ill.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Emanuel M. Lance		13b. MOTHER'S MAIDEN NAME Lillian Byrd	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME B. Finneran		ADDRESS 500 So. Kingshighway			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Meningitis		INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, ashenia, 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) _____			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Omphalocele		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) (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 **7-29-**, 19**55**, to **10-1-**, 19**55**, that I last saw the deceased alive on **10-1**, 19**55**, and that death occurred at **7:30 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE Leslie J. Vietti MD		(Degree or title) Childrens Hosp.		23b. ADDRESS	
23c. DATE SIGNED 10-1-55		24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 10-2-55	
24c. NAME OF CEMETERY OR CREMATORY Madison, Illinois		24d. LOCATION (City, town, or county) (State)			

DATE REC'D BY LOCAL REG. OCT 3 1955		REGISTRAR'S SIGNATURE J. Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE Lahey, Madison, Illinois	
25. FUNERAL DIRECTOR'S ADDRESS					

(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.....
Licensed Embalmer No. 45
P. O. Address St. Louis

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.