

THE DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATHState File No. **38530**
Registrar's No. **9930**

FILED NOV 25 1955

BIRTH NO.

REG. DIST. NO.

318

PRIMARY REG. DIST. NO.

1003

Registrar's No.

1. PLACE OF DEATH
a. COUNTYb. CITY (If outside corporate limits, write RURAL and give township)
OR TOWN SAINT LOUISc. LENGTH OF STAY (in this place)
2 daysd. FULL NAME OF HOSPITAL OR INSTITUTION
JEWISH HOSPITAL2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE MISSOURI: b. COUNTY COUNTY

c. CITY OR TOWN UNIVERSITY CITY

e. STREET ADDRESS (If rural, give location)
7442 STRATFORD AVE:3. NAME OF DECEASED
(Type or Print)

a. (First)

BASIL

b. (Middle)

MANLY

c. (Last)

LIDE JR.

4. DATE OF DEATH (Month) (Day) (Year)
NOV 12 19555. SEX
MALE6. COLOR OR RACE
WHITE7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
MARRIED8. DATE OF BIRTH
JULY 8 18939. AGE (In years last birthday) 62
UNDER 1 YEAR Months Days
UNDER 1 Mtn. Hours Mtn.10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED - ST. LOUIS DAIRY CO. (PRESIDENT)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and State or Foreign Country)
MARION, ALABAMA12. CITIZEN OF WHAT COUNTRY?
U. S. A.

13a. FATHER'S NAME

BASIL MANLY LIDE

13b. MOTHER'S MAIDEN NAME

MALLIE HOWZE

14. NAME OF HUSBAND/OR WIFE

MARIE DIERKES LIDE

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)
YES. W.W.#1.16. SOCIAL SECURITY NO.
492-07-852717. INFORMANT'S SIGNATURE OR NAME ADDRESS
MARIE DIERKES LIDE 7442 STRATFORD AVE.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.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)

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.

MEDICAL CERTIFICATION

Dissecting aneurysm of aorta

Polyarteritis nodosum

Hypertension

INTERVAL BETWEEN ONSET AND DEATH

20 hours

3 yrs.

3 yrs.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

456X

20. AUTOPSY?

YES NO

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) (Minute)

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 12, 1948 to Nov 12, 1955, that I last saw the deceased alive on Nov 12, 1955, and that death occurred at 9:15 a.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)

M. Norman Oryel

23b. ADDRESS

M.D. 508 North Grand

23c. DATE SIGNED

11-14-55

24a. BURIAL, CREMATION, REMOVAL (Specify)

24b. DATE

15-NOV-55

24c. NAME OF CEMETERY OR CREMATORY

OAK GROVE CEMETERY

24d. LOCATION (City, town, or county) (State)

ST. LOUIS COUNTY, MISSOURI

DATE REC'D BY LOCAL REG.
NOV 14 1955

REGISTRAR'S SIGNATURE

C. R. Lupton & Sons

25. FUNERAL DIRECTOR'S SIGNATURE

C. R. LUPTON & SONS- 7233 DELMAR BLV'D.

ADDRESS

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 *Clarence H. Murray*.....

Licensed Embalmer No. *4011*

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.