

FILED JAN 6 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42490

State File No.

318

1003

Registrar's No. 10961

| | | | | | | | | | |
|---|--|---|---|--|--|---|--|----------------------------------|--|
| BIRTH NO. _____ | | REG. DIST. NO. _____ | | PRIMARY REG. DIST. NO. _____ | | Registrar's No. _____ | | | |
| 1. PLACE OF DEATH a. COUNTY _____ | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____ | | | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Mo.</u> | | c. LENGTH OF STAY (in this place) <u>1 day 19 hrs.</u> | | c. CITY OR TOWN <u>St. Louis</u> | | 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 <u>Lutheran Hospital</u> | | | | e. STREET ADDRESS (If rural, give location) <u>6600a Pennsylvania 20170</u> | | | | | |
| 3. NAME OF DECEASED (Type or Print) | | | a. (First) <u>Lillian P.</u> b. (Middle) <u>Pape.</u> c. (Last) _____ | | | 4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 13, 1955</u> | | | |
| 5. SEX <u>female</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u> | | 8. DATE OF BIRTH <u>Apr. 11, 1881</u> | | | |
| 9. AGE (In years last birthday) <u>74</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u> | | 11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo.</u> | | | |
| 11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis, Mo.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13a. FATHER'S NAME <u>Julius Scheske</u> | | 13b. MOTHER'S MAIDEN NAME <u>Sophia Schlundt</u> | | | |
| 13a. FATHER'S NAME <u>Julius Scheske</u> | | 13b. MOTHER'S MAIDEN NAME <u>Sophia Schlundt</u> | | 13c. NAME OF HUSBAND OR WIFE <u>Edward C. Pape</u> | | 14. NAME OF HUSBAND OR WIFE <u>Edward C. Pape</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT'S SIGNATURE OR NAME <u>Edw. C. Pape</u> | | ADDRESS <u>6600a Pennsylvania</u> | | | |
| 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. | | | | MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute myocardial infarction</u> | | | | DUE TO (b) <u>Coronary artery thrombosis</u> | | | | <u>6 days</u> | |
| ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. | | | | DUE TO (c) _____ | | | | <u>6 days</u> | |
| 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 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) <u>4201</u> | | 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 <u>12/11</u> , 19 <u>55</u> , to <u>12/13</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/13</u> , 19 <u>55</u> , and that death occurred at <u>1210p</u> m., from the causes and on the date stated above. | | | |
| 23a. SIGNATURE (Degree or title) <u>Edward W. Gehrinski M.D.</u> | | 23b. ADDRESS <u>3701 Grandel Sq</u> | | 23c. DATE SIGNED <u>12/14/55</u> | | 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | | |
| 24b. DATE <u>12-16-55</u> | | 24c. NAME OF CEMETERY OR CREMATORY <u>St. Pauls Churchyard</u> | | 24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Southern Funeral Home</u> | | | |
| DATE REC'D BY LOCAL REG. <u>DEC 14 1955</u> | | REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u> | | ADDRESS <u>6322 S. Grand Blvd., St. Louis, Mo.</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Southern Funeral Home</u> | | | |

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Ed. Czebrinski

Grandell Med. Center.

1 to 3 p.m.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by, Student Embalmer No.

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *David Van F...*

Licensed Embalmer No. *43*

P. O. Address *S. Law*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.