

Health,  
Welfare  
Public  
Service

300  
1-56

0  
All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. No symptoms will be listed. Use only standard nomenclature in item 10. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JUN 29 1956

21953  
STATE FILE NUMBER  
318 Primary Registration District No. 1003 Registrar's No. 5880

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5880

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		Length of stay in 1b	d. STREET ADDRESS <b>329 Belt Ave.</b>		(If outside, give location) <b>2129</b> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Pearl</b> Middle <b>Elizabeth</b> Last <b>Lawler</b>			4. DATE OF DEATH Month <b>July</b> Day <b>20</b> Year <b>1956</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> <b>2</b> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 25-1884</b>	9. AGE (In years last birthday) <b>72</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>Fort Worth, Texas</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Phillip Willing</b>			14. MOTHER'S MAIDEN NAME <b>Susan O. Flint</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT Address <b>Mrs. H. Carey Korndoerfer, St. Louis, Mo.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of stomach (primary site)</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.					DUE TO (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>151X</b>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour - Month, Day, Year a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>June 12, 1956</b> to <b>June 20, 1956</b> and last saw her <b>alive on June 20, 1956</b> Death occurred at <b>5:30 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <i>C. R. Lupton, M.D.</i> (Degree or title)			22b. ADDRESS <b>BARNES HOSPITAL</b> <b>M. D.</b>		22c. DATE SIGNED <b>6/21/56</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Entombment</b>		23b. DATE <b>6-22-1956</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Mausoleum</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis Co., Mo.</b>
24. FUNERAL DIRECTOR <b>C. R. Lupton &amp; Sons</b>		ADDRESS <b>7233 Delmar Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>JUN 21 1956</b>	26. REGISTRAR'S SIGNATURE <i>J. Earl Smith, M.D.</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

(Licensed Embalmer's Statement on Reverse Side)

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. Mur*

Licensed Embalmer No. *401*

P. O. Address *St. Louis*

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