

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **28745**
7648

FILED SEP 6 1956

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 Mo. b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN St. Louis		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 DePaul Hospital				e. STREET ADDRESS (If rural, give location) 3927 St. Louis Ave. <i>21190</i>			
3. NAME OF DECEASED (Type or Print) a. (First) Lillian		b. (Middle) C.		c. (Last) Lennon		4. DATE OF DEATH (Month) (Day) (Year) Aug. 17 1956	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Oct. 1 1878	
9. AGE (In years last birthday) 77		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 12 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 _____			11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME John Kelly		13b. MOTHER'S MAIDEN NAME Hannah Kelly		14. NAME OF HUSBAND OR WIFE Charles W. Lennon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. ROBO		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Charles W. Lennon 3927 St. Louis 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia, lobar, terminal Pneumonia, lobar, terminal ANTECEDENT CAUSES DUE TO (b) general art-scler Arteriosclerotic heart dis. DUE TO (c) art-scler heart disease II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs ?	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input 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) 420 D			
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 8-16-56 , 1955 , to Aug 17, 1956 , that I last saw the deceased alive on Aug 16 1956 , and that death occurred at 3:15 A.M. from the causes and on the date stated above. 8-17-56							
23a. SIGNATURE L.D. Cassidy (Degree or title) _____				23b. ADDRESS 4952 Maryland 4952 Maryland		23c. DATE SIGNED 8-17-56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8/20/56		24c. NAME OF CEMETERY OR CREMATORY Calvary		24d. LOCATION (City, town, or county) (State) St. Louis Mo.	
DATE REC'D BY LOCAL REG. AUG 17 1956		REGISTRAR'S SIGNATURE J. Earl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Sullivan's 2849 No. Euclid Ave.			

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

Dr L Cassidy
4952 Maryland

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 *Albert Rayfee*.....

Licensed Embalmer No. 307.....

P. O. Address.....

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.