

FILED APR 22 1957

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PRIMARY REG. DIST. NO. **1003**Registrar's No. **3203**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. 14898		
BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 3203		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE Missouri b. COUNTY _____				
b. CITY OR TOWN St. Louis, Mo.		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 St. Johns Hospital				e. STREET ADDRESS (If rural, give location) 2505 N. Grand St.				
3. NAME OF DECEASED (Type or Print) a. (First) Alice b. (Middle) _____ c. (Last) Killian			4. DATE OF DEATH (Month) (Day) (Year) March 31 1957					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow		8. DATE OF BIRTH June 4, 1886		
9. AGE (In years last birthday) 70		IF UNDER 1 YEAR Months 9 Days 28		IF UNDER 24 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) Jackson Mo.		12. CITIZEN OF WHAT COUNTRY? USA.	
13a. FATHER'S NAME Silas Sider			13b. MOTHER'S MAIDEN NAME unknown			14. NAME OF HUSBAND OR WIFE Glenn Killian		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 495 52 3072		17. INFORMANT'S SIGNATURE OR NAME John Shehane ADDRESS 3935a Blomac St. 495 52 3072				
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.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of ovary - metastasis to visceral & parietal peritoneum & abdominal lymph nodes ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH 13 years	
II. OTHER SIGNIFICANT CONDITIONS Hemohydro peritoneum, bilateral hydrothorax, Atelectasis maxime lung inferior							7 months	
19a. DATE OF OPERATION 10/1/56		19b. MAJOR FINDINGS OF OPERATION As noted above.					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) SUICIDE		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) N/A		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) N/A				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) N/A		21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> WHILE ON WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? N/A				
22. I hereby certify that I attended the deceased from Sept 30, 1956 , to 31 March 1957 , that I last saw the deceased alive on 31 March 1957 , and that death occurred at 30 m., from the causes and on the date stated above.								
23a. SIGNATURE A. E. Heigel M.D. (Degree or title)				23b. ADDRESS 307 S. Euclid St. Louis Mo		23c. DATE SIGNED 1 April, 1957		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE April 3rd 1957		24c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery, St. Charles, Mo.		24d. LOCATION (City, town, or county) (State) St. Charles, Mo.		
DATE REC'D BY LOCAL REGS. APR 3 1957		REGISTRAR'S SIGNATURE Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Dull-Campbell Mortuary ADDRESS 65 Selma St.				

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

~~John H. ...~~
~~...~~

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 *John H. ...*.....
Licensed Embalmer No. *365*
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.