

FILED MAY 10 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **14966**
Registrar's No. **4184**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

| | | | | | |
|--------------------------------|--|--|--|-----------|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE | | b. COUNTY | |
|--------------------------------|--|--|--|-----------|--|

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|---|--|-----------------------------------|--|----------------------------------|--|---|--|
| 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"/> | |
|---|--|-----------------------------------|--|----------------------------------|--|---|--|

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|---|--|--|---|--|--|
| d. FULL NAME OF HOSPITAL OR INSTITUTION 26 St. Louis Chronic Hosp. | | | e. STREET ADDRESS (If rural, give location) 3626 N. Market St. | | |
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|--|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or Print) Tillie Lipke | | | 4. DATE OF DEATH (Month) (Day) (Year) 5 1 1957 | | |
|--|--|--|--|--|--|

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|----------------------|--|-------------------------------|--|--|--|-------------------------------------|--|---|--|------------------------|--|----------------------|--|------------------------|--|-----------------------|--|
| 5. SEX female | | 6. COLOR OR RACE white | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Div. | | 8. DATE OF BIRTH. Oct 7 1878 | | 9. AGE (In years last birthday) 78 | | IF UNDER 1 YEAR Months | | IF UNDER 1 YEAR Days | | IF UNDER 24 HRS. Hours | | IF UNDER 15 MIN. Min. | |
|----------------------|--|-------------------------------|--|--|--|-------------------------------------|--|---|--|------------------------|--|----------------------|--|------------------------|--|-----------------------|--|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sewer | | | 10b. KIND OF BUSINESS OR INDUSTRY Hat & Dress Ind | | | 11. BIRTHPLACE (City and State or Foreign Country) Mo. | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
|--|--|--|--|--|--|---|--|--|---|--|--|

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|--|--|--|--|--|--|---|--|--|
| 13a. FATHER'S NAME Herman ? Lipke | | | 13b. MOTHER'S MAIDEN NAME Caroline Strack | | | 14. NAME OF HUSBAND OR WIFE unk. Theodore Hill | | |
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| 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. 499-28-1970 | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Stella Lipke 2800 Osgood Overland Mo | | | |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) | | MEDICAL CERTIFICATION | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| <p>*This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.</p> | | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Left Ovarian Adenocarcinoma | | | | | | 6 weeks | |
| | | ANTECEDENT CAUSES | | | | | | | |
| | | Morbidity 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. Cerebral Arteriosclerosis | | | | | | 2 yrs. | |

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| 19a. DATE OF OPERATION March '57 | | 19b. MAJOR FINDINGS OF OPERATION Carcinomatous of Viscera 175x | | | | | | 20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO | |
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| 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) | |
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|--|--|--|--|----------------------------|--|
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 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 **4-25-57**, 19____, to **5-1-57**, 19____, that I last saw the deceased alive on **5-1-57**, 19____, and that death occurred at **8:40a m.**, from the causes and on the date stated above.

| | | | | | | | | |
|---|--|--|--------------------------------------|--|--|--------------------------------|--|--|
| 23a. SIGNATURE (Degree or title) John H. Beckham, M.D. | | | 23b. ADDRESS 5800 Arsenal St. | | | 23c. DATE SIGNED 6/1/57 | | |
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| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24b. DATE May 3 57 | | 24c. NAME OF CEMETERY OR CREMATORY SunSet Burial Park | | 24d. LOCATION (City, town, or county) (State) St. Louis Cty Mo | |
|--|--|---------------------------|--|--|--|---|--|

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| DATE REC'D BY LOCAL REG. MAY 2 '57 | | REGISTRAR'S SIGNATURE J. Earl Smith, M.D. | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS E.J. Schnur 3125 Lafayette | |
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G.P. (Licensed Embalmer's Statement on Reverse Side)

PR 1-7780

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 *Thomas R. Penwick*

Licensed Embalmer No. *3793*

P. O. Address *3125 Lafayette*

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.