FILED JUN 7 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 19001

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4686

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St.Louis — Inside Limits Yes X No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): St.Luke's Hospital — Length of stay in Hospital: 10 Days

2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission)
a. STATE: Missouri
b. COUNTY: St Louis
c. CITY OR TOWN: Normandy — Inside Limits Yes X No ☐
d. STREET ADDRESS (If outside, give location): 914 Country Club Dr. — Reside on Farm Yes ☐ No X

3. NAME OF DECEASED (Type or print): First: Alice Middle: NMN Last: McCormack
4. DATE OF DEATH: Month May Day 16 Year 1957
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 21,1887
9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (City and state or country): St.Louis,Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Louis Lumelius
14. MOTHER'S MAIDEN NAME: Mary Schroher
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT (Husband) Address: Mr Walter S.McCormack 914 Country Club

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Meningioma of Brain — INTERVAL BETWEEN ONSET AND DEATH: 1yr?
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): 223x
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑ ?
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 5-10-57, to 5-16-57 and last saw her alive on 5-16-57
Death occurred at 3 P m on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE George W. Ettner (Degree or title) M.D.
22b. ADDRESS 3720 Washington Blvd.
22c. DATE SIGNED 5-17-57
23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: May 18,1957
23c. NAME OF CEMETERY OR CREMATORY: Oak Grove Mausoleum
23d. LOCATION (City, town, or county) (State): St.Louis,Co;Missouri
24. FUNERAL DIRECTOR ADDRESS: Alexander & Sons 6175 Delmar Blvd
25. DATE RECD. BY LOCAL REG.: MAY 17 '57
26. REGISTRAR'S SIGNATURE: J Earl Smith MD

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, Coroner, etc. must use only standard nomenclature in Item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

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

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Jos. E. McCullah

Licensed Embalmer No. 24

P. O. Address 6145 L

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.