

S. No. 300  
v. 10 48

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

27046

State File No. \_\_\_\_\_

FILED JUL 25 1957

Registrar's No. 1761

|   |  |   |  |   |  |  |   |  |  |
|---|--|---|--|---|--|--|---|--|--|
| BIRTH NO. _____   |  | REG. DIST. NO. 317  |  | PRIMARY REG. DIST. NO. 500  |  | State File No. _____   |   | Registrar's No. 1761   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>St Louis</u>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <u>MO.</u> b. COUNTY <u>St Louis</u> |  |  |   |  |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Loch</u>  |  |   | c. LENGTH OF STAY (in this place) <u>5 yrs 2 mos</u> |   | c. CITY OR TOWN <u>St Louis</u>  |  | d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Robert Koch Hospital</u>   |  |   |  | e. STREET ADDRESS (If rural, give location) <u>212 5139 Cates</u>   |  |  |   |  |  |
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <u>EMMA</u>   |  |   | b. (Middle) <u>MAE</u>                               |   | c. (Last) <u>LACY</u>  |  | 4. DATE OF DEATH (Month) (Day) (Year) <u>July 12, 1957</u>  |  |  |
| 5. SEX <u>F</u>   |  | 6. COLOR OR RACE <u>W</u>   |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>   |  | 8. DATE OF BIRTH <u>10-9-29</u>                                    |   | 9. AGE (In years last birthday) <u>27</u> IF UNDER 1 YEAR: Months <u>9</u> Days <u>3</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nil</u>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>   |  | 11. BIRTHPLACE (City and State or Foreign Country) <u>Arkansas</u> |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13a. FATHER'S NAME <u>J. M. Adams</u>   |  |   | 13b. MOTHER'S MAIDEN NAME <u>Eva Holder</u>          |   |  | 14. NAME OF HUSBAND OR WIFE <u>Ernest Lacy</u>                     |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>no</u>   |  |   | 16. SOCIAL SECURITY NO. <u>none</u>                  |   | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Koch Hosp. Records - Koch, Mo</u> |  |   |  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br><i>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.</i>                           |  | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Pulmonary hemorrhage</u><br><br>ANTECEDENT CAUSES<br><u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u><br>DUE TO (b) <u>Pulmonary Tuberculosis</u><br><br>DUE TO (c) _____<br><br>II. OTHER SIGNIFICANT CONDITIONS<br><i>*Conditions contributing to the death but not related to the disease or condition causing death.</i> |  |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>15 minutes</u><br><u>11 years</u>   |  |
| 19a. DATE OF OPERATION _____  |  | 19b. MAJOR FINDINGS OF OPERATION _____  |  |   |  |  |   | 20. AUTOPSY? <u>2</u><br>YES <input type="checkbox"/> NO <input checked="" 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) <u>002X</u>   |  |  |   |  |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) _____  |  | 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 <u>April 25, 1957</u> to <u>July 12, 1957</u> , that I last saw the deceased alive on <u>July 12, 1957</u> , and that death occurred at <u>3:25 P.M.</u> , from the causes and on the date stated above. |  |   |  |   |  |  |   |  |  |
| 23a. SIGNATURE (Degree or title) <u>Samuel Friedman, M.D.</u>   |  |   |  | 23b. ADDRESS <u>Robert Koch Hospital, Loch, Mo.</u>   |  |  | 23c. DATE SIGNED <u>7-12-57</u>   |  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>  |  | 24b. DATE <u>7-13-57</u>  |  | 24c. NAME OF CEMETERY OR CREMATORY <u>Loch</u>  |  | 24d. LOCATION (City, town, or county) (State) <u>Corning, Ark.</u> |   |  |  |
| DATE REC'D BY LOCAL REG. <u>7/13/57</u>   |  | REGISTRAR'S SIGNATURE <u>Herbert A. Dembich</u>   |  |   | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Russell-Ermert, Corning, Ark.</u>  |  |   |  |  |

Koch to El. Adams

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 *Andrey P. Gaellier Jr*

Licensed Embalmer No. *4950*

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.