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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Coroner, 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.

FILED OCT 4 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 33357

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9016

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Inside Limits Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): 14 Jewish Hospital — Length of stay in 1b: 2 d

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits Yes ☐ No ☐
STREET ADDRESS (If outside, give location): 5954 North Pointe — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First AMELIA Middle I. Last COLLINS
4. DATE OF DEATH: Month Sept. Day 25, Year 1957
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Dec. 16, 1883
9. AGE (In years last birthday): 73 — 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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (City and state or country): St. Louis, Missouri
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: William Helbig
14. MOTHER'S MAIDEN NAME: Louisa Rappenacher
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: Oliver Collins Address: 5954 North Pointe

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): Metastatic Lympho-Sarcoma — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Lympho-Sarcoma - L. Axillary Node — 3 yr.
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
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.): 200.1
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 Jan 1953, to Sep 25-57 and last saw her/him alive on 9-25-57
Death occurred at 2:15 P/M on the date stated above; and to the best of my knowledge, from the causes stated.
22a. SIGNATURE (Degree or title): P. D. Stahl M. D.
22b. ADDRESS: 462 N. Taylor
22c. DATE SIGNED: 9/27/57

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 9/28/57
23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery
23d. LOCATION (City, town, or county) (State): St. Louis, Missouri
24. FUNERAL DIRECTOR: JOHN STYGAR & SON ADDRESS: 5541 Riverview
25. DATE RECD. BY LOCAL REG.: SEP 27 '57
26. REGISTRAR'S SIGNATURE: J. Earl Smith, M.D.
5.02

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

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

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

working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed J. W. Rister

Licensed Embalmer No. 39

P. O. Address St. Louis

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.