

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

33798

FILED SEP 18 1957

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STATE FILE NUMBER 8260

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Creve Coeur		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DePaul Hospital		Length of stay in lb 7 days	d. STREET ADDRESS (If outside, give location) 14 Garden Lane		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frances Middle M. Last Lineback			4. DATE OF DEATH Month 9 Day 2 Year 57			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 23, 1902	9. AGE (In years last birthday) 55	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoe Worker - Ret.		10b. KIND OF BUSINESS OR INDUSTRY Shoe	11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Boyle			14. MOTHER'S MAIDEN NAME Agnes Cavanaugh			
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. 493-09-9288	17. INFORMANT Address Mr. Louis Lineback, Maryland Heights			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of liver with general metastases DUE TO (b) Metastases. DUE TO (c) 156.1 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cholelithiasis					INTERVAL BETWEEN ONSET AND DEATH MO. -	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.						
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) 8-26-57	20f. CITY, TOWN, OR LOCATION COUNTY STATE 9-2-57				
21. I attended the deceased from 2:15 8-26-57 to 9-2-57 and last saw her alive on 9-2-57. 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) Eugene J. O'Malley M.D.			22b. ADDRESS 634 N. Grand		22c. DATE SIGNED 9-7-57	
23a. BURIAL, CREMATION, REMOVAL (Specify) removal	23b. DATE 9/5/57	23c. NAME OF CEMETERY OR CREMATORY St. Monica Cemetery		23d. LOCATION (City, town, or county) (State) Creve Coeur Mo.		
24. FUNERAL DIRECTOR ADDRESS Drehmann-Harral 1905 Union		25. DATE RECD. BY LOCAL REG. SEP 4 57	26. REGISTRAR'S SIGNATURE Carl Smith mo			

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

Dr. Eugene J. O'Malley
DePaul Hospital

Leave certificate Admitting
Office 9/4 10 AM

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was ex-
amined by me, or by Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Albert R. Thompson*

Licensed Embalmer No. *42*

P. O. Address *St. Paul*

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.