

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-011663
STATE FILE NUMBER
Registrar's No. 3650

FILED APR 9 1958

Registration District No. 318 Primary Registration District No. 1003

300
-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY	
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 ST. LOUIS
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION O/ 4248² SHENANDOAH		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 17 4248² SHENANDOAH
3. NAME OF DECEASED (Type or print) First LILLIAN Middle Last GIVAN			4. DATE OF DEATH Month MAR Day 30 Year 1958
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 29 1869
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (City and state or country) MISSOURI
13a. FATHER'S NAME WILLIAM RENO		13b. MOTHER'S MAIDEN NAME NANCY HUGGINS	14. NAME OF HUSBAND OR WIFE EPHRAIM GIVAN (DECD)
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	17. INFORMANT Address MABEL SEARS 4248² SHENANDOAH
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Disease			INTERVAL BETWEEN ONSET AND DEATH 3mo
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Generalized Arteriosclerosis			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 420.0			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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.) 2	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <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.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from January 6 1958 to March 30 58 and last saw her alive on March 29 1958 Death occurred at IAI m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE B. J. Mc Ginnis M.D. (Degree or title)		22b. ADDRESS 16 Hampton Kelley Plaza	22c. DATE SIGNED 3/31/58
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
REMOVAL	APRIL 1 1958	I. O. O. F CEMETERY	SHELBYNA MO
24. FUNERAL DIRECTOR Thomas Hutto 2906 Gravois ADDRESS		25. DATE RECD. BY LOCAL REG. MAR 31 '58	26. REGISTRAR'S SIGNATURE Carl Smith MD

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

*Office
at
221-2561*

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 *Henry A. Barkelov*

Licensed Embalmer No. *3835*
P. O. Address *Sheelbina M*

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.