

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-016066  
STATE FILE NUMBER

XC-1750 091  
SL 16583  
FILED MAY 8 1958

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 4675

300  
-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILLINOIS b. COUNTY PULASKI	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N. GRAND, ST. LOUIS, MO.		c. CITY OR TOWN MOUND CITY	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VET. ADM. HOSPITAL		d. STREET ADDRESS (If outside, give location) 627 MAIN STREET	
3. NAME OF DECEASED (Type or print) HERBERT LANCASTER		4. DATE OF DEATH APRIL 29, 1958	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/2/90
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) PERCY, MISSISSIPPI
13a. FATHER'S NAME HARDY LANCASTER		13b. MOTHER'S MAIDEN NAME SARAH HOPKINS	14. NAME OF HUSBAND OR WIFE PATSY LANCASTER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES		16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT VA HOSPITAL RECORDS, ST. LOUIS, MO.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage; left thoracic cavity. DUE TO (b) Dissecting aneurysm of aorta with rupture of thoracic aorta DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 3-4 days
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> NONE <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 <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 4/28/58 to 4/29/58 and last saw him alive on 4/29/58 Death occurred at 4:30 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) G. WADE GRANBERRY M.D.		22b. ADDRESS VAH, ST. LOUIS, MISSOURI	22c. DATE SIGNED 4/29/58
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE 4/30/58	23c. NAME OF CEMETERY OR CREMATORY NATIONAL CEMETERY	23d. LOCATION (City, town, or county) (State) CAIRO, ILLINOIS
24. FUNERAL DIRECTOR G. WADE GRANBERRY 4202 FINNEY AVE.		25. DATE RECD. BY LOCAL REG. APR 30 '58	26. REGISTRAR'S SIGNATURE J. Smith, No. 248.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

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 *Edward A. Flynn* .....

Licensed Embalmer No. 4444 .....

P. O. Address 4202 Finney Av .....

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.