

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-019688

STATE FILE NUMBER

FILED JUN 11 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5488

S. 300
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>ST. LOUIS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>13 INCARNATE WORD HOSP. 2790</u>			Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>3415 MAGNOLIA</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>LILLIAN BARBARA FORST</u>				4. DATE OF DEATH Month Day Year <u>MAY 23 1958</u>					
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG 21 1909</u>		9. AGE (In years last birthday) <u>48</u>	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) <u>SUPERVISOR</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>BELL TELEPHONE</u>		11. BIRTHPLACE (City and state or country) <u>ST. LOUIS MO 0</u>		12. CITIZEN OF WHAT COUNTRY? <u>U-S-A.</u>		
13a. FATHER'S NAME <u>AUGUST WILLIAM FORST</u>			13b. MOTHER'S MAIDEN NAME <u>LENA V SVJKOSKY</u>			14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>492-07-7608</u>		17. INFORMANT Address <u>MELVIN BOGDANOVICH 3959 WYOMING</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of mediastinum</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Cancer of Rt Breast (?)</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Mastectomy 12 yrs ago for cancer</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 wks</u> <u>12 yrs</u>		
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.) <u>170x</u>						
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 <u>3-17-58</u> to <u>5-23-58</u> and last saw her alive on <u>5-23-58</u> Death occurred at <u>1000</u> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) <u>S. Dworkin MD</u>				22b. ADDRESS <u>1657 Grand</u>				22c. DATE SIGNED <u>5/26/58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)			
<u>BURIAL</u>		<u>MAY 27 1958</u>		<u>RESURRECTION CEM.</u>		<u>ST. LOUIS, MO, MO</u>			
24. FUNERAL DIRECTOR <u>Thomas Kutia 2906 Gravois</u>			25. DATE RECD. BY LOCAL REG. <u>MAY 26 '58</u>		26. REGISTRAR'S SIGNATURE <u>Carol Smith MD</u> <u>58</u>				

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1657 J. - Stewart

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 C. Hill*

Licensed Embalmer No. *4347*
P. O. Address *2906 Lewis*

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.