

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-045989

STATE FILE NUMBER

12615

FILED JAN 14 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

300
-57

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		c. CITY OR TOWN Maplewood 4534	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Marian Hospital		d. STREET ADDRESS (If outside, give location) 27 2286 Yale Ave.	
3. NAME OF DECEASED (Type or print) First Middle Last LILLIE MAY McCALLISTER		4. DATE OF DEATH Month Day Year Dec. 26 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 May 30, 1872
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (City and state or country) Council Bluff, Iowa
13a. FATHER'S NAME William Walter Gilson		13b. MOTHER'S MAIDEN NAME Elizabeth Huber	14. NAME OF HUSBAND OR WIFE Late Harvey McCallister
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No None		16. SOCIAL SECURITY NO. None	17. INFORMANT Address James C. Jennings 4920 Walsh St.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart disease</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>contusion of Left Hip joint</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>420.0 F</i>			INTERVAL BETWEEN ONSET AND DEATH <i>Dec 22-1958</i>
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.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Death occurred at <i>Dec 22 1958</i> 8:50 P.		and last saw her alive on <i>Dec 26-1958</i>	
22a. SIGNATURE (Degree or title) <i>H. J. Moore M.D.</i>		22b. ADDRESS <i>917-5018</i>	22c. DATE SIGNED <i>12-29-1958</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE <i>Dec. 30, 1958</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Lake Charles Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis Co. Mo.</i>
24. FUNERAL DIRECTOR ADDRESS <i>Kriegshauser 4228 S. Kingshighway</i>		25. DATE RECD. BY LOCAL REG. <i>DEC 29 1958</i>	26. REGISTRAR'S SIGNATURE <i>Carl Snied</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

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 *Richard J. Stoveland*

Licensed Embalmer No. *4007*

P. O. Address

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.