

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-006923
STATE FILE NUMBER
2 1364

REG. FEB 24 1959 Registration District No. _____ Primary Registration District No. _____ Registrar No. _____

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, MO.		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOS P. #1.		d. STREET ADDRESS (If outside, give location) 4330 W. Papin	
3. NAME OF DECEASED (Type or print) First Middle Last LILLIE BRADY		4. DATE OF DEATH Month Day Year FEB . 6, 1959	
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 4-2-1883
9. AGE (In years last birthday) 75		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (City and state or country) Cuba, Mo.
10a. FATHER'S NAME Edward Lickliger		10b. KIND OF BUSINESS OR INDUSTRY Home	12. CITIZEN OF WHAT COUNTRY? U.S. A.
13a. FATHER'S NAME Edward Lickliger		13b. MOTHER'S MAIDEN NAME Lisa Jane Wright	14. NAME OF HUSBAND OR WIFE Phillip Brady
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. Unk.	17. INFORMANT Address St. Louis, Mo. Charles Shoults, 4330 W. Papin
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Infarction Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) Pulmonary Embolism DUE TO (c) 465X			INTERVAL BETWEEN ONSET AND DEATH
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 <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 1/30/59 to 2/6/59 and last saw her/him alive on 2/6/59 Death occurred at 1 P.M. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>M.S. Johnson M.D.</i> (Degree or title)		22b. ADDRESS 1515 LAFAYETTE AVE	
22c. DATE SIGNED 2/6/59			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-9-59	23c. NAME OF CEMETERY OR CREMATORY Laurel Hills Cem.	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
24. FUNERAL DIRECTOR Aker, 4104 Manchester, St. Louis, Mo.		25. DATE RECD. BY LOCAL REG. FEB 9 '59	
26. REGISTRAR'S SIGNATURE <i>Earl Smith, M.D.</i>			

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 *James M. Billo*

Licensed Embalmer No. *4375*
P. O. Address *St. Louis, Mo.*

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.