Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-019615
STATE FILE NUMBER

FILED MAY 18 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2,4550

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St. Louis, Mo. — Inside Limits: Yes [X] No [ ]
c. FULL NAME OF HOSPITAL OR INSTITUTION: Masonic Home of Mo. — Length of stay in this place: 10-17-54 to 5-8-59

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 5351 Delmar Blvd. — Reside on Farm: Yes [ ] No [ ]

3. NAME OF DECEASED (Type or print): First: Lillian — Middle: A — Last: Seidel

4. DATE OF DEATH: Month: 5 — Day: 8 — Year: 59

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED [ ] **NEVER MARRIED** [ ] **WIDOWED** [X] **DIVORCED** [ ]

8. DATE OF BIRTH: May 26, 1877

9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months: 11, Days: — IF UNDER 24 HRS.: Hours: , Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City and state or country): St. Louis, Mo.

12. CITIZEN OF WHAT COUNTRY?: USA

13a. FATHER'S NAME: George E. Leyh

13b. MOTHER'S MAIDEN NAME: Caroline F. Koch

14. NAME OF HUSBAND OR WIFE: Frank Seidel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): unknown — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Masonic Home of Missouri — Address: 5351 Delmar Blvd.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Ovary with generalized metastasis — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 175.0
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] **SUICIDE** [ ] **HOMICIDE** [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

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 1-56, to 5-8-59 and last saw her/him alive on 5-7-59
Death occurred at 5:25 a m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Harold E. Walters M.D.

22b. ADDRESS: 3720 Washington St. Louis Mo.

22c. DATE SIGNED: 5-8-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 5/11/59

23c. NAME OF CEMETERY OR CREMATORY: Old St. Marcus Cemetery

23d. LOCATION (City, town, or county) (State): St. Louis, Missouri

24. FUNERAL DIRECTOR ADDRESS: Alexander & Sons 6175 Delmar Blv

25. DATE RECD. BY LOCAL REG.: MAY 9 '59

26. REGISTRAR'S SIGNATURE: Earl Smith, M.D. S.P.

(Licensed Embalmer's Statement on Reverse Side)

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 Jas. E. McCulloh

Licensed Embalmer No. 2960

P. O. Address 6175 Delmar

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.