

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-026654

FILED VS JUL 24 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's **2 6555** STATE FILE NUMBER

IDED

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY					
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		Length of stay in 1b		c. CITY OR TOWN ST. LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) 3906 WALSH		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First LILLIAN Middle FRIEDRICH Last				4. DATE OF DEATH Month JULY Day 10 Year 1959					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH MAR 24 1907		9. AGE (last birthday) 52 IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HR: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TYPIST			10b. KIND OF BUSINESS OR INDUSTRY CITY HOSPITAL		11. BIRTHPLACE (City and state or country) INDIANA		12. CITIZEN OF WHAT COUNTRY U-S-A		
13a. FATHER'S NAME HENRY WOOD			13b. MOTHER'S MAIDEN NAME LOUISE KATHARINE HAEUSER			14. NAME OF HUSBAND OR WIFE			
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. 498-14-6970		17. INFORMANT LOUISE FRIEDRICH Address 3906 WALSH				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction							INTERVAL BETWEEN ONSET AND DEATH 1 wk		
DUE TO (b) Metastatic Carcinoma in abdomen with									
DUE TO (c) Carcinoma of Rectum							1 yr.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 154x						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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 _____ a.m. _____ p.m. Month, Day, Year _____		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 1-17-56 to 7/10/59 and last saw her 1 hr alive on 7/10/59 Death occurred at 4:15 P. m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) Frank A. Bailey M.D.				22b. ADDRESS 3108 So. Grand				22c. DATE SIGNED 7/11/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE JULY 13 1959		23c. NAME OF CEMETERY OR CREMATORY LAKE CHARLES CEM		23d. LOCATION (City, town, or county) ST. LOUIS MO			
24. FUNERAL DIRECTOR Thomas Kutis 2906 Gravois ADDRESS				25. DATE RECD. BY LOCAL REG. JUL 11 1959		26. REGISTRAR'S SIGNATURE Earl Smith M.D. mgs			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

6789

before 7:30 AM '57

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 Eleanor Province

Licensed Embalmer No. 3403

P. O. Address 2906 Gra

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.