

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-004100

FILED VS FEB 1 0 1960

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. **2 973** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS MO</b>		Length of stay in 1b <b>6 WEEKS</b>	c. CITY OR TOWN <b>ST. LOUIS</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. JOHNS HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4440 MANCHESTER</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>LILLIAN CHRISTIANA STEINBANK</b>			4. DATE OF DEATH Month Day Year <b>1 26 60</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>2-18-1887</b>
9. AGE (last birthday) <b>72</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MO</b>
12. CITIZEN OF WHAT COUNTRY <b>U. S. A</b>		13a. FATHER'S NAME <b>JOHN HOLLOWOOD</b>	
13b. MOTHER'S MAIDEN NAME <b>CHRISTINE LAGARSE</b>		14. NAME OF HUSBAND OR WIFE <b>WILLIAM STEINBANK</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>497-07-9689</b>	17. INFORMANT Address <b>WILLIAM STEINBANK 4440 MANCHESTER</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the ovary with extensive metastases</b> DUE TO (b) <b>extensive metastases</b> DUE TO (c) <b>175.0</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Broncho-pneumonia</b>			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 checked="" type="checkbox"/> NO <input 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 <b>12-25-59</b> to <b>1-26-60</b> and last saw her/him alive on <b>1-26-60</b> Death occurred at <b>12:25 PM</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>James S. Hickey M.D.</b>		22b. ADDRESS <b>4931 Parkview Pl.</b>	22c. DATE SIGNED <b>1-27-60</b>
23a. BURYAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>1-30-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>CALVARY CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>LITTLE ROCK, ARK.</b>
24. FUNERAL DIRECTOR <b>HOWARD H. MICHEL 5930 SOUTHWEST</b>		25. DATE RECD. BY LOCAL REG. <b>JAN 27 1960</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b> <b>MJS</b>

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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

*U. C. Morris*

Licensed Embalmer No. 3360

P.O. Address St. Louis

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.