

JR DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-021588

FILED VS MAY 25 1960

318

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5096

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

| | | | |
|---|--|---|--|
| 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 | | c. CITY OR TOWN ST. LOUIS | |
| Length of stay in 1b | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL | | d. STREET ADDRESS (If outside, give location) 3435 MINNESOTA | |
| Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | |

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|---|----------------------------------|---|--|---|---|---|--|
| 3. NAME OF DECEASED (Type or print) First Middle Last LILLIAN H STOLL | | | 4. DATE OF DEATH Month Day Year MAY 13 1960 | | | | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH FEB 10. 1893 | 9. AGE (last birthday) 67 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK | | 10b. KIND OF BUSINESS OR INDUSTRY AT HOME | | 11. BIRTHPLACE (City and state or country) MISSOURI | | 12. CITIZEN OF WHAT COUNTRY U-S-A | |
| 13a. FATHER'S NAME JOHN STADLER | | 13b. MOTHER'S MAIDEN NAME EMMA GLASER | | 14. NAME OF HUSBAND OR WIFE WALDEMAR STOLL | | | |
| 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. NONE | | 17. INFORMANT Address WALDEMAR STOLL 3435 MINNESOTA | | | |

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|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN DEATH AND DEATH |
| IMMEDIATE CAUSE (a) Pulmonary artery thrombosis | | 2 days |
| DUE TO (b) Arteriosclerosis | | years |
| DUE TO (c) 332X | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Cerebrovascular thrombosis 4 mo. Effluvia terminalis Ulcerative colitis | | 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 |

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|--|---|--|--|
| 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 May 3 '60 to 8:05 P.M. and last saw her/him alive on May 13 '60 Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated. | | | | |

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|---|---------------------------------|---|--|------------------------------------|
| 22a. SIGNATURE (Degree or title) R. a. Neuberger MD | | 22b. ADDRESS 5701 Grandel St | | 22c. DATE SIGNED 5-14-60 |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE MAY 16 1960 | 23c. NAME OF CEMETERY OR CREMATORY CONCORDIA CEM. | 23d. LOCATION (City, town, or county) ST. LOUIS MO | (State) |

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|--|--|--|
| 24. FUNERAL DIRECTOR Thomas Kutis 2906 Gravois | 25. DATE RECD. BY LOCAL REG. MAY 16 1960 | 26. REGISTRAR'S SIGNATURE Earl Smith, M.D. |
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

TH H O

0 11-3-65

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____

working (under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Elean Province

Licensed Embalmer No. 3403

P. O. Address 2906 Jean

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.