

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-046158

FILED JAN 5 1962

318

Primary Registration District No. 1003

Registrar's No. 12074

STATE FILE NUMBER

AMENDED

DATE AMENDED

INSTEAD OF

DOCUMENT

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>NEW YORK</u> b. COUNTY <u>NEW YORK</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST-LOUIS</u>		Length of stay in 1b <u>5 MOS -</u>		c. CITY OR TOWN <u>NEW YORK</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>HOME</u> <u>LITTLE FLOWER CONVALESCENT</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>318 N. 8ND ST.</u>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>LILLIAN EVALD CARLSON</u>				4. DATE OF DEATH Month Day Year <u>DEC-24, 1961</u>				
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>12/2/1886</u>		
9. AGE (last birthday) <u>75</u>		IF UNDER 1 YEAR Months Days Hours Min.		9. AGE (last birthday) <u>75</u>		IF UNDER 24 HR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (City and state or country) <u>CHICAGO, ILL.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>DR. CARL EVALD</u>			13b. MOTHER'S MAIDEN NAME <u>DR. EMMY CARLSSON</u>			14. NAME OF HUSBAND OR WIFE <u>AMEL R. CARLSON</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>KIRKWOOD, MD.</u> Address <u>MRS. EMMY C. McRATT 2139 BRIARGATE LANE</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>Cerebral Hemorrhage (12/15/61)</u> Arteriosclerotic disease DUE TO (b) <u>Arteriosclerotic disease</u> DUE TO (c) <u>331X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>Chronic</u>		
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 <u>8-1-61</u> to <u>12-24-61</u> and last saw her/him alive on <u>12-23-61</u> Death occurred at <u>4 P.M.</u> <u>48</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>E. A. Lanschke</u> (Degree or title) <u>E. A. Lanschke M.D.</u>				22b. ADDRESS <u>6303 Natural Bridge</u> <u>6303 Natural Bridge</u>		22c. DATE SIGNED <u>12-25-61</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>12-26-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GRAELAND CEMETERY</u>		23d. LOCATION (City, town, or county) <u>CHICAGO, ILL.</u>		
24. FUNERAL DIRECTOR <u>PELTZINGER MORTUARY, KIRKWOOD, MO.</u>				25. DATE RECD. BY LOCAL REG. <u>DEC 25 1961</u>		26. REGISTRAR'S SIGNATURE <u>Loed Smith, M.D.</u>		

SHOULD READ

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

*Benjamin Hoffmann*

Licensed Embalmer No. 4366

P. O. Address Kirkwood, 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.