

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-033298

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 317 Primary Registration District No. 543 Registrar's No. 2394

LED SEP 4 1962

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Jennings</u> Length of stay in 1b <u>YRS.</u> c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Hightower Home</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>ST. LOUIS</u> c. CITY OR TOWN <u>Jennings</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>2136 Hord Ave</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
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3. NAME OF DECEASED (Type or print) First Middle Last <u>Celia Uelik.</u>			4. DATE OF DEATH Month Day Year <u>8-16-1962</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>8-31-1876</u>	9. AGE (last birthday) <u>85</u>	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) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (City and state or country) <u>ST. LOUIS, MO</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>
13a. FATHER'S NAME <u>Edw. Specker</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Angela Lake</u>		14. NAME OF HUSBAND OR WIFE <u>William.</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 Address <u>Francis Farwig 2136 Hord</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>Arteriosclerotic Cardiovascular disease unknown</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Pulmonary emphysema, Senile dementia</u>	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 Jan 15, 1962 to Aug 16, 1962 and last saw her alive on Aug 15, 1962
 Death occurred at 2 A m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Lewis Lillmann MD</u>		22b. ADDRESS <u>8231 Clayton Rd (17)</u>		22c. DATE SIGNED <u>8/17/62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>8-18-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>		23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO</u>

24. FUNERAL DIRECTOR <u>O'Sullivan Muckle Kron</u>		ADDRESS <u>8806</u>	25. DATE RECD. BY LOCAL REG. <u>8-17-62</u>	26. REGISTRAR'S SIGNATURE <u>John B. Mumfry MD</u>
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 1 4008
 2 4008
 3 2
 4 1
 5 2
 6
 7 0
 8 2
 9 4221
 10
 11
 12 86-0
 13
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ
 USE BLACK INK OR TYPEWRITER RIBBON

L. E. Williams
8231 Clayton Road
Pa 70202
3-15-72

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,

~~by~~ _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Lawrence O. Becking

Licensed Embalmer No. 4979

P. O. Address Berkeley, 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.