

FILED MAY 13 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17605

State File No.

318

1003

Registrar's No. 4145

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY _____				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Missouri</u>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		17 9 0		
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. JOHN'S HOSPITAL</u>				d. STREET ADDRESS (If rural, give location) <u>5315 No. Euclid Ave.,</u>				
3. NAME OF DECEASED (Type or Print) a. (First) <u>LILLIAN</u> b. (Middle) <u>PURTELL</u> c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>MAY 6, 1949</u>					
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>Nov. 27th 1869</u>		
9. AGE (In years last birthday) <u>79 yrs.</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 10 SEEL. 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 _____		11. BIRTHPLACE (State or foreign country) <u>Louisville, Kentucky /</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Charles Schreiber</u>			13b. MOTHER'S MAIDEN NAME <u>Elizabeth Nilest</u>		14. NAME OF HUSBAND OR WIFE <u>MR. MICHAEL F. PURTELL</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'S SIGNATURE OR NAME ADDRESS <u>MRS. MICHAEL PURTELL, 5315 N. Euclid</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c): *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Hemorrhage</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Hypertension</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>83</u>				
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>331X</u>				
22. I hereby certify that I attended the deceased from <u>April 1949</u> to <u>May 6, 1949</u> , that I last saw the deceased alive on <u>May 6, 1949</u> , and that death occurred at <u>4:15 a.m.</u> , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <u>[Signature]</u>				23b. ADDRESS <u>3903 Park Ave.</u>		23c. DATE SIGNED <u>5-7-49</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>5-9-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Int. Memorial Pk. Cem</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Missouri</u>		
DATE REC'D BY LOCAL <u>MAY 9 1949</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Sullivan Fun. Dir. 2849 N. Euclid</u>				

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Robert K. Highland

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 _____

working under my personal supervision.

Student Embalmer No. _____

Signed.....
Student Embalmer

Signed

Robert L. Brinkman
Licensed Embalmer No. 3553
P. O. Address _____

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 this body is not embalmed, fact should be so stated above.