

FILED JUN 15 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 17851
5073

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		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, write RURAL and give OR TOWN St. Louis, Missouri)		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2019	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION St. Louis City Hospital #1				d. STREET ADDRESS (If rural, give location) 4129 Concordia Ave.			
3. NAME OF DECEASED (Type or Print) LILLIAN		a. (First)		b. (Middle) BOUSE		c. (Last)	
4. DATE OF DEATH MAY 31 1951		5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Widow	
8. DATE OF BIRTH Aug. 11, 1875		9. AGE (In years last birthday) 75		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		11. BIRTHPLACE (State or foreign country) St. Louis, Mo.	
12. CITIZEN OF WHAT COUNTRY? 0		13a. FATHER'S NAME Joseph Meyer		13b. MOTHER'S MAIDEN NAME Unknown Baum		14. NAME OF HUSBAND OR WIFE Late Joseph Bouse	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Mabel Franz ADDRESS 4129 Concordia Ave.			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Embolism ANTECEDENT CAUSES DUE TO (b) Thrombophlebitis of hypogastric veins DUE TO (c) Retrocecal abscess due to acute appendicitis with perforation II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus					
19a. DATE OF OPERATION 5-31-51		19b. MAJOR FINDINGS OF OPERATION Retrocecal abscess				20. AUTOPSY? YES <input checked="" 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) _____		21f. HOW DID INJURY OCCUR? 550.1	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I hereby certify that I attended the deceased from 5-24-51 , 19____, to 5-31-51 , 19____, that I last saw the deceased alive on 5-31-51 , 19____, and that death occurred at 12:05 Pm. , from the causes and on the date stated above.			
23a. SIGNATURE J. E. Hilgers M.D. (Degree or title)		23b. ADDRESS 1515 Lafayette Avenue		23c. DATE SIGNED 5-31-51			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Jun. 2, 1951		24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park		24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.	
DATE REC'D BY LOCAL REG. JUN 1		REGISTRAR'S SIGNATURE J. B. Louder		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Kriegshauer 4228 S. Kingshighway Bl.			

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

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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
Student Embalmer

Signed.....

Richard W. Stovesand

Licensed Embalmer No. 4007

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.