

FILED MAR 7 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **6305**
Registrar's No. **1538**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 1538							
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY _____									
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. LENGTH OF STAY (In this place) 1 Month		c. CITY OR TOWN St. Louis, Mo.		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
d. FULL NAME OF HOSPITAL OR INSTITUTION Incarinate Word Hospital				e. STREET ADDRESS (If rural, give location) 5823 Loran									
3. NAME OF DECEASED (Type or Print) a. (First) William			b. (Middle) James		c. (Last) Lilburn		4. DATE OF DEATH (Month) (Day) (Year) February 15, 1955						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH April 5, 1889		9. AGE (In years last birthday) 65		10. UNDER 1 YEAR Months _____ Days _____		11. UNDER 1 HR. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work denoting most of working life, even if retired) Foreman				10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (City and State or Foreign Country) Ireland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME Thomas Lilburn				13b. MOTHER'S MAIDEN NAME Jane Unk.				14. NAME OF HUSBAND OR WIFE Carrie Lilburn.					
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. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Carrie Lilburn, 5823 Loran, St. Louis, Mo.							
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) Pulmonary Embolism INTERVAL BETWEEN ONSET AND DEATH Instant ANTECEDENT CAUSES DUE TO (b) Pleural Effusion 2 Mos DUE TO (c) Arteriosclerotic Heart Disease 5 yrs Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.											
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) _____					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4200									
22. I hereby certify that I attended the deceased from November 19 54 , to Feb. 15 , 19 55 , that I last saw the deceased alive on Feb. 15 , 19 55 , and that death occurred at 11:30 P.M. from the causes and on the date stated above.													
23a. SIGNATURE Rosemary Radkin, M.D.						23b. ADDRESS 3284 Ivanhoe		23c. DATE SIGNED 2-17-55					
24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		24b. DATE 2-18-1955		24c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory				24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.					
DATE REC'D BY LOCAL REG. FEB 17 1955		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.				25. FUNERAL DIRECTOR'S SIGNATURE McLaughlin Funeral Home, Inc.		ADDRESS 2301 Lafayette, St. Louis 4, Mo.					

S.P. (Licensed Embalmer's Statement on Reverse Side)

3284 Swain, hae.

1 - Larkin - 1030

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *James R. Chapman*
Licensed Embalmer No. *45*
P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.