

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JUL 9 1956

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State File No. 22147

Registrar's No. 5847

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			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN				c. LENGTH OF STAY (in this place)		b. COUNTY	
d. FULL NAME OF HOSPITAL OR INSTITUTION				c. CITY OR TOWN		d. Is Residence within limits of a city or incorporated town? <input type="checkbox"/> No <input type="checkbox"/> Yes	
3. NAME OF DECEASED (Type or Print)				e. STREET ADDRESS (If rural, give location)		4. DATE OF DEATH (Month) (Day) (Year)	
a. (First)		b. (Middle)		c. (Last)		LOUISE C. STUART JUNE 20 1956	
5. SEX		6. COLOR OR RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH	
FEMALE		WHITE		DIVORCED		FEB. 25 1892	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)	
MACHINE OPERATOR				BECKER CO		64	
11a. FATHER'S NAME				11b. MOTHER'S MAIDEN NAME		11. BIRTHPLACE (City and State or Foreign Country)	
ADOLPH GLIEFORST				THERESA BAMBERGER		ST. LOUIS MO	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS	
				498-03-625		KATHERINE SCHIRMER AFFTON 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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)				INTERVAL BETWEEN ONSET AND DEATH	
		Chondrosarcoma of pelvis				4 years	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
		DUE TO (b) Generalized metastases					
		DUE TO (c) 196X					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		Chondrosarcoma involving left ilium and most of left thigh.					
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)			
No							
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?			
22. I hereby certify that I attended the deceased from May 8 1954, to June 19, 1956, that I last saw the deceased alive on June 19, 1956, and that death occurred at 6:30 a.m., from the causes and on the date stated above.							
23a. SIGNATURE J. Otto Lottes M.D. (Degree or title)				23b. ADDRESS		23c. DATE SIGNED	
[Signature]				16 Hampton Village Plaza		6/20/56	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State)	
BURIAL		JUNE 21 1956		ST. MATTHEWS CEM.		ST. LOUIS MO	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
JUN 20 1956		[Signature]		[Signature] 2906 [Address]			

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

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

Geoff Budda

Licensed Embalmer No. *3989*

P. O. Address *St. Louis*

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.