

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 29 1957

STATE FILE NUMBER **2603**
206

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. _____

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, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION 01 215 So. Taylor Ave.			Length of stay in lb 3 mo. 2/19/57		d. STREET ADDRESS (If outside, give location) 215 So. Taylor		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Lillian Carroll				4. DATE OF DEATH Month Day Year Jan. 6 1957					
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 4, 1866		9. AGE (In years last birthday) 90	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (City and state or country) Lebanon, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Neal Craig				14. MOTHER'S MAIDEN NAME Unknown					
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. No		17. INFORMANT Address Vera Finley 215 So. Taylor Ave.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction due to Arterio-sclerotic Coronary Thrombosis							INTERVAL BETWEEN ONSET AND DEATH hours		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							DUE TO (b) _____		
							DUE TO (c) _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							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 Month, Day, Year a. m. p. m.									
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 10-8-56 to 1-6-57 and last saw her alive on 11-21-56 Death occurred at 11:55 P m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE (Degree or title) Wm Higgins, M.D.				22b. ADDRESS 634 N. Grand Ave.			22c. DATE SIGNED 1-8-57		
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE Jan. 9, 1957	23c. NAME OF CEMETERY OR CREMATORY Resurrection Cemetery			23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.			
24. FUNERAL DIRECTOR ADDRESS Hoffmeister Colonial Mortuary 616 Chippewa St., St. Louis, Mo.				25. DATE RECD. BY LOCAL REG. JAN 8 '57		26. REGISTRAR'S SIGNATURE Earl Smith MO MFB			

(Licensed Embalmer's Statement on Reverse Side)

300
-56

All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms written on certificate. At

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

APR 16 1957

1-5:30 pm Tues

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em-
by me, or by Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Linus C. Hoffmann*

Licensed Embalmer No. 381

P. O. Address 7814 S. H.

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