

Health, Welfare Public Service

300 1-56

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

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
General: Benign Tumor

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6520 STATE FILE NUMBER

FILED FEB 25 1957

318

1003

985

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis				c. CITY OR TOWN Litchfield		b. COUNTY Montgomery	
c. FULL NAME OF (If NOT in hospital, give location) St. John's Hospital				Length of stay in lb 2 weeks		d. STREET ADDRESS (If outside, give location) 420 E. Columbia	
3. NAME OF DECEASED (Type or print) Anna Rosalie Picaman				4. DATE OF DEATH Jan. 28, 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 4, 1891	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (City and state or country) Litchfield, Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles Reed				14. MOTHER'S MAIDEN NAME Delia O. Loughlin			
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. Unknown		17. INFORMANT Address Mrs. William Volansky, 529 Kingston Dr.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <i>Benign Tumor</i> 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) <i>223x</i>						INTERVAL BETWEEN ONSET AND DEATH <i>1 yr</i>	
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 <i>1/14/57</i> to <i>1/28/57</i> and last saw her alive on <i>1/28/57</i> . Death occurred at <i>9:30</i> A. m. on the date stated above; and to the best of my knowledge, from the cause stated.							
22a. SIGNATURE E. A. Smolik				22b. ADDRESS 3720 Washington, St. Louis 8, Mo.		22c. DATE SIGNED 1/30/57	
23a. BURIAL, CREMATION REMOVAL (Specify) Removal		23b. DATE 1-28-57		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION (City, town, or county) (State) Litchfield, Ill.	
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, 4700. Washington Blvd.				25. DATE RECD. BY LOCAL REG. JAN 30 '57		25. REGISTRAR'S SIGNATURE <i>Carl Smith</i>	

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 *Stanley H. Win*.....

Licensed Embalmer No. *47*

P. O. Address *St. L.*

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