

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED SEP 17 1957

34190
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8169

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Madison	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN Quincy	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) 1675 Main Street., 32	
3. NAME OF DECEASED (Type or print) First Middle Last LILLIAN FRANCES STILLWELL		4. DATE OF DEATH Month Day Year AUGUST 30, 1957	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 23, 1896
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) Kansas City, Missouri.
13a. FATHER'S NAME Frank Pierson		13b. MOTHER'S MAIDEN NAME Ida Berg	14. NAME OF HUSBAND OR WIFE Richard Stillwell
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. None	17. INFORMANT John Stillwell, Quincy, Illinois.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF ESOPHAGUS (PRIMARY SITE) DUE TO (b) DUE TO (c) 150X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 6 MOS.
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 <input type="checkbox"/> NOT WHILE 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 AUGUST 21, 1957 to AUGUST 30, 1957 and last saw her alive on AUGUST 30, 1957 Death occurred at 1:30 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>C. D. Remmelin, M.D.</i>		22b. ADDRESS BARNES HOSPITAL	
		22c. DATE SIGNED 8/30/57	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 8-31-57	
23c. NAME OF CEMETERY OR CREMATORY Local		23d. LOCATION (City, town, or county) (State) Quincy, Illinois.	
24. FUNERAL DIRECTOR Albert H. Hoppe, 4700 Washington Blvd.,		25. DATE RECD. BY LOCAL REG. SEP 3 '57	
		26. REGISTRAR'S SIGNATURE <i>J. Carl Smith</i>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

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 *Elmo R. Cadwell*

Licensed Embalmer No. *4077*
P. O. Address *St. Louis, Mo.*

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.