

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH -61-038251

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9371 STATE FILE NUMBER

FILED OCT 26 1961

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis, Mo.</u>		c. CITY OR TOWN <u>St. Louis.</u>	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Incarnate Word Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>1232a Sidney, St.</u>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>M.</u> Last <u>Arning</u>			4. DATE OF DEATH Month <u>October</u> Day <u>9</u> Year <u>1961</u>		
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11/29/1892</u>	9. AGE (last birthday) <u>68</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and state or country) <u>Hartford City, Indiana, U.S.A.</u>	12. CITIZEN OF WHAT COUNTRY
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13a. FATHER'S NAME <u>Isam Channel</u>	13b. MOTHER'S MAIDEN NAME <u>Jessie Steele</u>	14. NAME OF HUSBAND OR WIFE <u>Alfred</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>	16. SOCIAL SECURITY NO. <u>Nil.</u>	17. INFORMANT <u>Alfred Arning, 1232a Sidney, St.</u>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the ascending colon</u>		INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	<u>153.0</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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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
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21. I attended the deceased from Aug 1 1959 to Oct 9-61 and last saw her ^{her} _{him} alive on 10-9-61
Death occurred at 11:30 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>B. J. Mc Guinis MD</u> (Degree or title)	22b. ADDRESS <u>16 Harvester Village</u>	22c. DATE SIGNED <u>10-9-61</u>
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23a. BURIAL, CREMATION REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>10-11-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23d. LOCATION (City, town, or county) <u>Quincy, Illinois.</u> (State)
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24. FUNERAL DIRECTOR <u>Albert H. Hoppe Inc., 4700 Washington, Blvd.</u> ADDRESS	25. DATE RECD. BY LOCAL REG. <u>OCT 10 1961</u>	26. REGISTRAR'S SIGNATURE <u>Road Smith, M.D.</u>
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DATE AMENDED
AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
SHOULD READ
BY AFFIDAVIT OF
ITEM NO.

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. Dixon

Licensed Embalmer No. 4193

P. O. Address St. L.

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.