

FILED FEB 9 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2238

819

BIRTH NO. <u>82137-49</u>		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. <u>819</u>			
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY <u>ST LOUIS</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Mo.</u>		c. LENGTH OF STAY (in this place) <u>5 weeks</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>4495 RICHMOND HEIGHTS</u>		d. STREET ADDRESS (If rural, give location) <u>1014 MOORLANDS DR.</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Evangelical Deaconess Hospital</u>									
3. NAME OF DECEASED (Type or Print) a. (First) <u>Susan</u> b. (Middle) <u>Bagley</u> c. (Last) <u>Ashby</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 14 1950</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>0</u>		8. DATE OF BIRTH <u>Dec. 10, 1949</u>			
9. AGE (In years last birthday) <u>1</u>		IF UNDER 1 YEAR Days <u>4</u>		IF UNDER 2 HRS. Hours <u>1</u> Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13a. FATHER'S NAME <u>William B. Ashby</u>			13b. MOTHER'S MAIDEN NAME <u>Virginia Brown Ashby</u>		14. NAME OF HUSBAND OR WIFE <u>1014 Moorlands VIRGINIA ASHBY</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS					
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) <u>Hydrocephalus (Congenital)</u> ANTECEDENT CAUSES <u>& Spina Bifida</u> Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>35 dy.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
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) <u>752X</u>					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		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 <u>Dec 10, 1949</u> , to <u>Jan 14, 1950</u> , that I last saw the deceased alive on <u>Jan 14, 1950</u> , and that death occurred at <u>7 P. m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree of title) <u>Edward C. Westrup, M.D.</u>				23b. ADDRESS <u>249 E. Pine</u>		23c. DATE SIGNED <u>1-17-50</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE <u>JAN 26 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>		24d. LOCATION (City, town, or county) (State)			
DATE REC'D BY LOCAL REG. <u>JAN 26 1950</u>		REGISTRAR'S SIGNATURE <u>L B Pasater 1</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Rowland Mortuary Service 4104 Manchester Ave.</u>					

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.

Signed.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

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 this body is not embalmed, fact should be so stated above.