

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

FILED FEB 24 1950

State File No. 6198  
 Registrar's No. 1440

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		State File No. <u>6198</u>		Registrar's No. <u>1440</u>	
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, write RURAL and give township) OR TOWN <u>St. Louis, Mo.</u>			c. LENGTH OF STAY (In this place) <u>10-27-49</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>			2769	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Infirmiry Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>26-1735A N-9th</u>					
3. NAME OF DECEASED (Type or Print) <u>ELLA</u>			a. (First)		b. (Middle) <u>FORD</u>		c. (Last)		
4. DATE OF DEATH <u>FEB 12 1950</u>		(Month) (Day) (Year)		5. SEX <u>Female</u>		6. COLOR OR RACE <u>Cal</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	
8. DATE OF BIRTH <u>March 29-1890</u>		9. AGE (In years last birthday) <u>59</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____		11. BIRTHPLACE (State or foreign country) <u>Miss /</u>	
10a. USUAL OCCUPATION (Kind of work done during most of working life, or if retired) <u>nil</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>nil</u>		12. CITIZEN OF WHAT COUNTRY? <u>Miss /</u>			13a. FATHER'S NAME <u>Hellis Herring</u>	
13b. MOTHER'S MAIDEN NAME <u>Lucinda mat Karver</u>			14. NAME OF HUSBAND OR WIFE _____			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____	
17. INFORMANT'S SIGNATURE OR NAME <u>Mary Woods</u>			ADDRESS <u>3200 Lucas</u>			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, asthma, etc. It means the disease, injury, or complication which caused death.			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral Thrombosis 3200 Lucas</u>				II. OTHER SIGNIFICANT CONDITIONS* Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY <u>yes</u> YES <input type="checkbox"/> NO <input checked="" 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>332X</u>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		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>Oct 27, 1949</u> to <u>Feb 12, 1950</u> , that I last saw the deceased alive on <u>Feb 12, 1950</u> , and that death occurred at <u>2:30P m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Clifford L. Krog M.D.</u>				(Degree or title)		23b. ADDRESS <u>5600 Arsenal St. St. Louis</u>		23c. DATE SIGNED <u>Feb-12-1950</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>2-18-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Washington Park</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo</u>		DATE REC'D BY LOCAL REG. <u>FEB 14 1950</u>	
REGISTRAR'S SIGNATURE <u>J. B. Susata</u>				25. FUNERAL DIRECTOR'S SIGNATURE <u>A. D. Richardson</u>					
ADDRESS _____				ADDRESS <u>2625 Kasper</u>					

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

*Handwritten mark*

**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 \_\_\_\_\_  
Student Embalmer

Signed *A. P. Richardson*

Licensed Embalmer No. *2928*

P. O. Address *2625 Glasgow*

**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.