

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

29741
7005

State File No.

FILED AUG 20 1953

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

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 OR TOWN <u>St. Louis</u>)		c. CITY OR TOWN <u>St. Louis</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>33yrs</u>		e. STREET ADDRESS (If rural, give location) <u>5 5611 Bartmer</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Res. 5611 Bartmer</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Ellen</u> b. (Middle) <u>Cousins</u> c. (Last) <u>Andrews</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>July 16, 1953</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Dec. 14, 1881</u>	9. AGE (In years last birthday) <u>71yrs</u> If UNDER 1 YEAR: Months _____ Days _____ If UNDER 24 HRS: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Secy. A. Leschen Rope Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <u>St. Louis Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>

13a. FATHER'S NAME <u>Geo. Cousins</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Allen</u>		14. NAME OF HUSBAND OR WIFE <u>Frank Andrews</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 None</u>		16. SOCIAL SECURITY NO. <u>492-05-0172</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Jessie Trowbridge 7107 Waterman</u>		
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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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of Sigmoid</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>with metastases</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>			INTERVAL BETWEEN ONSET AND DEATH
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19a. DATE OF OPERATION <u>About 1 yr. ago</u>	19b. MAJOR FINDINGS OF OPERATION <u>As above</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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? <u>153X</u>

22. I hereby certify that I attended the deceased from 1952, to 7/15, 1953, that I last saw the deceased alive on 7/6, 1953, and that death occurred at 1:30 pm, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>George A. Carroll M.D.</u>	23b. ADDRESS <u>607 N. Grand St. St. Louis Mo.</u>	23c. DATE SIGNED <u>7/16/53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>July 17, 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Bellefontaine Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u>
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DATE REC'D BY LOCAL REG. <u>JUL 16 1953</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>[Signature] 6175 Delmar</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Carrol
Rm # 3
Jefferson

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 *jos. E. McCulloch*

Licensed Embalmer No. *2460*

P. O. Address *6170 Pills*

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.