

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

2459

State File No.

FILED JAN 25 1954

BIRTH NO. _____ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 3058 Registrar's No. 44

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>	
b. CITY OR TOWN <u>St. Charles</u>		c. CITY OR TOWN <u>St. Charles, "Rural"</u>	
c. LENGTH OF STAY (in this place) <u>8-Days</u>		d. STREET ADDRESS (If rural, give location) <u>R.R. #1</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Joseph Hospital</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>JAMES</u> b. (Middle) <u>LEOPOLD</u> c. (Last) <u>EDELEN</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 20, 1954</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov. 21, 1861</u>
9. AGE (In years last birthday) <u>92</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life (even if retired)) <u>Farmer Ret</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life (even if retired)) <u>Farmer Ret</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Alonzo Edelen</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Davis</u>	14. NAME OF HUSBAND OR WIFE <u>Ella May Rogers (Dec'd.)</u>
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>None</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Lola Ralls, St. Charles Co., Mo.</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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute cholecystitis</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> ANTECEDENT CAUSES DUE TO (b) <u>Chemical peritonitis sec. to gall bladder rupture</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Senility 585x</u>	
19a. DATE OF OPERATION <u>Jan. 12, 1954</u>		19b. MAJOR FINDINGS OF OPERATION <u>Acute cholecystitis with perforation</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
24a. 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) 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>Jan. 12, 1954</u> , to <u>Jan. 20, 1954</u> , that I last saw the deceased alive on <u>Jan. 20, 1954</u> , and that death occurred at <u>1:04 P.M.</u> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <u>Russell Fisher, M.D.</u>		23b. ADDRESS <u>St. Charles Mo.</u>	23c. DATE SIGNED <u>Jan 21 1954</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Jan. 23, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>
DATE REC'D BY LOCAL REG. <u>Jan 21 1954</u>		REGISTRAR'S SIGNATURE <u>Francis Hamilton</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>W.C. Dallingwood, St. Char., Mo.</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.

Student

Student Embalmer

Signed

Frank R. Amalano

Licensed Embalmer No. _____

P. O. Address _____

St. Charles

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.