

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

13379

State File No. ....

4096

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. ....			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b>				b. COUNTY <b>ST. LOUIS</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS</b>		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <b>KIRKWOOD</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. LUKES HOSPITAL</b>				e. STREET ADDRESS (If rural, give location) <b>418 CLARK</b>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>WILLIAM</b>			b. (Middle) <b>BRUCE</b>			c. (Last) <b>EARLY</b>			
4. DATE OF DEATH <b>MAY 6, 1954</b>			5. SEX <b>Male</b>			6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>never married</b>	
8. DATE OF BIRTH <b>May 7, 1946</b>			9. AGE (in years last birthday) <b>7</b>		IF UNDER 1 YEAR Months <b>11</b> Days <b>29</b>		IF UNDER 24 HRS. Hours <b></b> Min. <b></b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pupil</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>school</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Missouri</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Robert M. Early.</b>			13b. MOTHER'S MAIDEN NAME <b>Kathryn Hirschi.</b>			14. NAME OF HUSBAND OR WIFE <b>none</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Mr. Robert M. Early;</b>			ADDRESS <b>418 Clark. Kirkwood</b>	
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) <b>Brain Tumor Verified</b> <b>Ependymoma, 4th ventricle</b> DUE TO (b) <b>Cushing, ulcer stomach</b> <b>perforation rec. to 1.</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 <b>approx 3 hrs</b> <b>3 hours</b>	
19a. DATE OF OPERATION <b>5/5/54</b>		19b. MAJOR FINDINGS OF OPERATION <b>Brain tumor piecing 4th ventricle</b>						20. AUTOPSY? YES <input checked="" 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) <b>193X</b>		(STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		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 <b>5-2</b> , 19 <b>54</b> , to <b>5-6</b> , 19 <b>54</b> , that I last saw the deceased alive on <b>5-6</b> , 19 <b>54</b> and that death occurred at <b>3:40P.m.</b> , from the causes and on the date stated above.									
23a. SIGNATURE <b>John E. Roubae</b> (Degree or title) <b>MD</b>				23b. ADDRESS <b>3720 Washington Ave</b>				23c. DATE SIGNED <b>5/6/54</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>5/7/1954</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Bellefontaine Cemetery, St. Louis, Mo.</b>		24d. LOCATION (City, town, or county) _____		(State) _____	
DATE REC'D BY LOCAL REG. <b>MAY 6 1954</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith MD</b>			25. FUNERAL DIRECTOR'S SIGNATURE <b>C.R. Lupton &amp; Sons; 7233 Delmar Blvd</b>				

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

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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 *Arnold W. Schoene*.....

Licensed Embalmer No. *386*.....

P. O. Address *St. Louis*.....

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.