

FILED JUL 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24268
Registrar's No. 6204

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Illinois</u> b. COUNTY <u>Madison</u>			
b. CITY (If outside corporate limits, write RURAL and give town) <u>St. Louis</u>		c. LENGTH OF STAY (In this place) <u>46 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>Collinsville</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>City Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>1200 Olive St.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Sue</u>		b. (Middle) _____		c. (Last) <u>BISHOP</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>7-7-54</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u>		8. DATE OF BIRTH <u>Aug. 1, 1952</u>	
9. AGE (In years last birthday) <u>1</u>		IF UNDER 1 YEAR Months <u>11</u> Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Erin, Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>Preston Bishop</u>		13b. MOTHER'S MAIDEN NAME <u>Marjorie Blass</u>		14. NAME OF HUSBAND OR WIFE _____			
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 <u>Marjorie Blass</u>		ADDRESS <u>above</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>Leukemia</u> ANTECEDENT CAUSES Morbid 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>8 mo.</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? 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) _____			
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? <u>2044</u>			
22. I hereby certify that I attended the deceased from <u>5-22-54</u> , 19 <u>54</u> , to <u>7-7-54</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>7-7-54</u> , 19 <u>54</u> , and that death occurred at <u>10:25 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Mary A. Davis, M.D.</u>				(Degree or title) _____		23b. ADDRESS <u>1515 Lafayette Avenue</u>	
23c. DATE SIGNED <u>7-8-54</u>		23d. NAME OF CEMETERY OR CREMATORY <u>St. John's</u>		24. LOCATION (City, town, or county) (State) <u>Collinsville Ill.</u>			
24a. DATE REC'D BY LOCAL REG. <u>JUL 8 1954</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Smith</u>		ADDRESS <u>Collinsville, Ill.</u>	

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

(Licensed Embalmer's Statement on Reverse Side)

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

W. H. Embalm

Signed _____

Otto J. Zwick

Licensed Embalmer No. 9137

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.