

FILED AUG 20 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. **28870****6249**

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 Co.</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) <b>7 yrs.</b>		c. CITY OR TOWN <b>Overland</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. Louis State Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>3357 Marshall Ave.,</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>BERNARD</b>		b. (Middle) <b>G.</b>		c. (Last) <b>ELFRINK</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>July 8, 1954.</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>Jan. 15, 1885</b>	
9. AGE (In years last birthday) <b>69</b>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 YEAR Hours _____ Min. _____		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <b>Leopold, Mo.</b>			
13a. FATHER'S NAME <b>George Elfrink</b>		13b. MOTHER'S MAIDEN NAME <b>Elizabeth Hollweg</b>		14. NAME OF HUSBAND OR WIFE <b>Jane Elfrink Dec.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Cecelia Elfrink, 3357 Marshall Ave.,</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*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>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral vascular accident</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Arteriosclerotic cardiac vascular disease</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>12 ds.</b>  <b>15 yrs</b>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				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) (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? <b>4221</b>			
22. I hereby certify that I attended the deceased from <b>Jan 1, 1953</b> , to <b>July 8, 1954</b> , that I last saw the deceased alive on <b>July 8, 1954</b> and that death occurred at <b>7:20 p.m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE <b>Philip R. Gae, M.D.</b> (Degree or title) _____				23b. ADDRESS <b>5400 Arsenal St.</b>		23c. DATE SIGNED <b>7/9/54</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>July 12/54</b>		24c. NAME OF CEMETERY OR CREMATORY <b>St. John Cem.,</b>		24d. LOCATION (City, town, or county) (State) <b>Leopold, Mo.</b>	
DATE REC'D BY LOCAL REG. <b>JUL 10 1954</b>		REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Jos. W. Clark 1125 Hodiamont Ave.,</b>			

(Licensed Embalmer's Statement on Reverse Side)

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.....  
Signature of Student Embalmer

Signed *Robert M. Murray*  
3749  
Licensed Embalmer No.....

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.