

FILED JAN 18 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **43555**
Registrar's No. **11450**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH
a. COUNTY City

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo.
b. COUNTY _____

b. CITY (If outside corporate limits, write RURAL and give township) City
c. LENGTH OF STAY (in this place) 4 mo. 2 days

c. CITY OR TOWN St. Louis.
d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION. St. Louis Chronic Hosp.

e. STREET ADDRESS (If rural, give location) 2189 18 4580 Wichita St.

3. NAME OF DECEASED
a. (First) Dan
b. (Middle) _____
c. (Last) Elle

4. DATE OF DEATH (Month) (Day) (Year)
12 13-1954.

5. SEX Male
6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) unknown

8. DATE OF BIRTH 1878

9. AGE (In years last birthday) 76
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) NONE

10b. KIND OF BUSINESS OR INDUSTRY _____

11. BIRTHPLACE (City and State or Foreign Country) Unknown

12. CITIZEN OF WHAT COUNTRY? unknown

13a. FATHER'S NAME Not Known

13b. MOTHER'S MAIDEN NAME Not Known

14. NAME OF HUSBAND OR WIFE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. _____

17. INFORMANT'S SIGNATURE OR NAME ADDRESS
Mrs. Dorothy Gerner, Kerrville, Texas

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, ashenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Arteriosclerosis
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

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES NO

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 NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? 334X

22. I hereby certify that I attended the deceased from 8-11, 1954, to 12-13, 1954, that I last saw the deceased alive on 12-12, 1954, and that death occurred at 5:55p. m., from the causes and on the date stated above.

22a. SIGNATURE Palmyra Buecum Rowlich M.D. (Degree or title)

23b. ADDRESS 5800 Arsenal Street

23c. DATE SIGNED 12/15/54

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation

24b. DATE 12-17-54

24c. NAME OF CEMETERY OR CREMATORY St. Louis City Crematory

24d. LOCATION (City, town, or county) (State) 5800 Arsenal

DATE REC'D BY LOCAL REG. DEC 16 1954

REGISTRAR'S SIGNATURE J. Earl Smith, M.D.

25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS James Ryan 5800 Arsenal

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..

Not embalmed

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.