

FILED FEB 7 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2948
0677
Registrar's No.

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS MO 6	c. LENGTH OF STAY (in this place)	c. CITY OR TOWN ST. LOUIS	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL #1		STREET ADDRESS (If rural, give location) 2239 2731 ^a ACCOMAC	

3. NAME OF DECEASED (Type or Print) a. (First) DOROTHY b. (Middle) P c. (Last) FELCH	4. DATE OF DEATH (Month) (Day) (Year) 1 22 55
--	--

5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH AUG-3-1916	9. AGE (In years last birthday) 38	IF UNDER 1 YEAR Months	IF UNDER 1 HRS. Days	IF UNDER 1 HRS. Hours	IF UNDER 1 HRS. Min.
------------------	---------------------------	---	--------------------------------	---------------------------------------	---------------------------	-------------------------	--------------------------	-------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (City and State or Foreign Country) MISSOURI 0	12. CITIZEN OF WHAT COUNTRY?
--	--	--	------------------------------

13a. FATHER'S NAME JAMES CAIN	13b. MOTHER'S MAIDEN NAME CLARA ERBS	14. NAME OF HUSBAND OR WIFE SYLVESTER FELCH
----------------------------------	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 492-01-0187	17. INFORMANT'S SIGNATURE OR NAME SYLVESTER FELCH	ADDRESS 2731 ^a Accomac
--	--	--	--------------------------------------

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		INTERVAL BETWEEN ONSET AND DEATH 4 yrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Diabetes Mellitus		
	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. Pulmonary Embolism Acute Pancreatitis		2 days

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? 260X
--	--	------------------------------------

22. I hereby certify that I attended the deceased from 1-12, 1955, to 1-22, 1955, that I last saw the deceased alive on 1-22, 1955, and that death occurred at 2:15 P., from the causes and on the date stated above.

23a. SIGNATURE C. Deeks M.D.	(Degree or Title)	23b. ADDRESS 1515 Lafayette Ave.	23c. DATE SIGNED 1-24-55
---------------------------------	-------------------	-------------------------------------	-----------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE JAN 25-1955	24c. NAME OF CEMETERY OR CREMATORY RESURRECTION	24d. LOCATION (City, town, or county) (State) ST LOUIS MO
--	--------------------------	--	--

DATE REC'D BY LOCAL REG. JAN 24 1955	REGISTRAR'S SIGNATURE Charles Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Thomas Katis	ADDRESS 2906 Glavinia
---	---	--	--------------------------

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

MRS B (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.....
Signature of Student Embalmer

Signed.....

Homer C Dill

Licensed Embalmer No. 434

P. O. Address 2906 St

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.