

FILED MAR 7 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6125**

1483

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 1483				
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) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) 1 day		c. CITY OR TOWN St. Louis		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 Incarinate Word Hospital			e. STREET ADDRESS (If rural, give location) 5616 Maple Avenue							
3. NAME OF DECEASED (Type or Print) WALTER			a. (First)		b. (Middle)		c. (Last) ELlicock			
4. DATE OF DEATH (Month) (Day) (Year) 2 15 55		5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed		8. DATE OF BIRTH July 7, 1869		
9. AGE (In years last birthday) 85		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? USA		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) piano tuner			10b. KIND OF BUSINESS OR INDUSTRY _____			13a. FATHER'S NAME James Ellicock		13b. MOTHER'S MAIDEN NAME Sarah Ann Glasby		
13c. NAME OF HUSBAND OR WIFE Sarita Florence Ellicock			14. NAME OF HUSBAND OR WIFE Sarita Florence Ellicock			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 490-36-7416	
17. INFORMANT'S SIGNATURE OR NAME Albert B. Ellicock			ADDRESS - 5616 Maple Avenue							
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) Acute Cardiac Congestion pressure congestion ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last: DUE TO (b) Bronchial Obstruction 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 1 hr		
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 (Month) (Day) (Year) (Hour) OF INJURY _____			21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 5705		22. I hereby certify that I attended the deceased from 2-14-55 , to 2-15-55 , that I last saw the deceased alive on 2-15 , 1955, and that death occurred at 2:55 P.m. , from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) Dr. J. J. Smith			23b. ADDRESS 1927 N. Main			23c. DATE SIGNED 2-16-55				
24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 2-17-55		24c. NAME OF CEMETERY OR CREMATORY Valhalla Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, County, Missouri				
DATE REC'D BY LOCAL REG. FEB 16 1955		REGISTRAR'S SIGNATURE J. C. Smith MO			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. R. Lupton & Sons-7233 Delmar Blv'd.,					

WRITE PLAINLY—USING UNFAADING 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 *Arnold W. Schoene*.....

Licensed Embalmer No. *3864*

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.