

FILED DEC 10 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41856
State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **11193**

1. PLACE OF DEATH
a. COUNTY _____
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN **St. Louis**
c. LENGTH OF STAY (in this place) township) **5 mos.**
2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE **Missouri** b. COUNTY _____
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 (If not in hospital or institution, give street address or location)
27 Homer Phillips Hospital
STREET ADDRESS (If rural, give location)
4222a Fairfax Avenue

3. NAME OF DECEASED (Type or Print)
a. (First) **ELNORA** b. (Middle) _____ c. (Last) **COMBER**
4. DATE OF DEATH (Month) (Day) (Year)
Nov. 19, 1957

5. SEX **Female** 6. COLOR OR RACE **Negro** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
Widowed 8. DATE OF BIRTH **1902** 9. AGE (In years last birthday) **approx. 55**
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)
Housewife 10b. KIND OF BUSINESS OR INDUSTRY **--**
11. BIRTHPLACE (City and State or Foreign Country)
Reserve, Louisiana 12. CITIZEN OF WHAT COUNTRY?
U. S. A.

13a. FATHER'S NAME **Unknown** 13b. MOTHER'S MAIDEN NAME **Poline ?** 14. NAME OF HUSBAND OR WIFE **Walter Comber**

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. **None** 17. INFORMANT'S SIGNATURE OR NAME ADDRESS
Willie M. Townsend 4222a Fairfax

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Myocardial Insufficiency**
ANTECEDENT CAUSES (b) **Coronary Arteriosclerosis**
DUE TO (c) **Advanced Nephrosclerosis**
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing 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)
4201

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred **10:26A** m., from the causes and on the date stated above.

23a. SIGNATURE **James M. Kelly** (Do not write in this space) 23b. ADDRESS **1300 Clark** 23c. DATE SIGNED **11-22-57**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 24b. DATE **11/26/57** 24c. NAME OF CEMETERY OR CREMATORY **Greenwood Cemetery** 24d. LOCATION (City, town, or county) (State)
St. Louis County, Mo.

DATE REC'D BY LOCAL REG. **NOV 22 57** REGISTRAR'S SIGNATURE **J. Bush Smith M.D.** 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
Charles J. Gates 4107 Finney Ave.

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..... *Guylton Swan*

Licensed Embalmer No. 4580.....

P. O. Address 4107 Finney. A

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.