

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-041669

FILED VS NOV 19 1959

210103

STATE FILE NUMBER

Registration District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		a. STATE <b>Missouri</b> b. COUNTY	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Enroute City Hospital</b>		c. CITY OR TOWN <b>St. Louis</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>4048 (rear) N. Broadway</b>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <b>Elsie</b> Middle <b>May</b> Last <b>White Christensen</b>			4. DATE OF DEATH Month <b>October</b> Day <b>29</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>8/30/1904</b>	9. AGE (last birthday) <b>55</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (City and state or country) <b>Alexander Co., Ill.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>
13a. FATHER'S NAME <b>Frank White</b>		13b. MOTHER'S MAIDEN NAME <b>Sarah Louise Elliott</b>		14. NAME OF HUSBAND OR WIFE <b>Andrew</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Alvie White, Route 1, Anna, Ill.</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subdural Hemorrhage Compound comminuted fracture of the Left Leg.</b>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (If noted under (a), (b), or (c) in PART I, do not repeat here.) <b>Supportive of death at noted under (a), (b), or (c) in PART I. If deceased was female was there a pregnancy in last 90 days.</b>		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 20.) <b>Fire (Explosion) struck in the vicinity of Broadway and Farrar St. Injury 525 pm on 10-29-59.</b>
20c. TIME OF INJURY Hour <b>6:25</b> p.m. Month, Day, Year <b>10-29-59</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>265 Street</b>
20f. CITY, TOWN, OR LOCATION <b>St. Louis Mo</b>		COUNTY STATE
21. I attended the deceased from <b>550 P.</b> and last saw her him alive on _____ Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.		

22a. SIGNATURE (Degree or title) <b>Patrick Taylor Carroul</b>		22b. ADDRESS <b>1300 Clark</b>		22c. DATE SIGNED <b>11-2-59</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>11-2-59</b>	23c. NAME OF CEMETERY OR CREMATORY <b>National Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Jefferson Barracks, Mo.</b>	
24. FUNERAL DIRECTOR <b>Albert H. Hoppe, Inc., 4700 Washington Blvd.</b>		25. DATE RECD. BY LOCAL REG. <b>NOV 3 1959</b>	26. REGISTRAR'S SIGNATURE <b>Earl Smith, M.D.</b>	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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**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 Melvin L. Kempe

Licensed Embalmer No. 4052

P. O. Address 4911 W. 1st 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.