

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH
FILED VS APR 22 1960

-60-016779

2 3994

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) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri		c. CITY OR TOWN St. Louis	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis City Hospital #1		d. STREET ADDRESS (If outside, give location) 1927 So. 10th St.	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Dora Middle Eldridge Last			4. DATE OF DEATH Month April Day 9 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/11/1880	9. AGE (last birthday) 80	IF UNDER 1 YEAR IF UNDER 24 HR Months Days 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 At Home		11. BIRTHPLACE (City and state or country) Bruno, Mo.		12. CITIZEN OF WHAT COUNTRY U.S.
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Mary Reed		14. NAME OF HUSBAND OR WIFE Louis (Obie)		
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 Address Louis (Obie) Eldridge, 1927 So. 10th St.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure		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) 434.1	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from **4-6-60** to **4-9-60** and last saw her/him alive on **4-9-60**
 Death occurred at **12:10a.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE David H. Mc Kenna, M.D. (degree or title)	22b. ADDRESS 1515 Lafayette Ave.	22c. DATE SIGNED 4-9-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 4-9-60	23c. NAME OF CEMETERY OR CREMATORY Local Cemetery	23d. LOCATION (City, town, or county) (State) DesArc, Mo.
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24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd.	25. DATE RECD. BY LOCAL REG. APR 11 1960	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
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DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

APR 27 1960

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed JW Bumbley

Licensed Embalmer No. 365

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.