

MISSOURI DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

ED MAR 28 1961
AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2582 STATE FILE NUMBER 10565

1. PLACE OF DEATH a. COUNTY <u>St. Louis Missouri</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>2 Days.</u>	c. CITY OR TOWN <u>St. Louis 4 Mo.</u>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Firmin Desloge Hosp.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>944 Ruther St.</u>
		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Ella Middle Cashion Last Cashion 4. DATE OF DEATH Month March Day 16 Year 1961

5. SEX F. 6. COLOR OR RACE W. 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH 9-6-82 9. AGE (last birthday) 78

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Home 11. BIRTHPLACE (City and state or country) Missouri 12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME McCambell Anderson 13b. MOTHER'S MAIDEN NAME Melissa Unton 14. NAME OF HUSBAND OR WIFE George (Deceased)

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. Unknown 17. INFORMANT Henry Cashion, Rt. 1, Herman, Mo. Address

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

IMMEDIATE CAUSE (a) EMBOLIC OCCLUSION OF LEFT CORONARY ART. UNKNOWN

CONDITIONS, if any, which gave rise to above cause (a), starting the underlying cause last, DUE TO (b) UNDETERMINED

DUE TO (c) 420.1 H

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) CHOLECYSTITIS + CHOLELITHIASIS AND CARCINOMA OF BREAST

PART III. If deceased was female was there a pregnancy in last 90 days. Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour 4:15 Month, Day, Year 15 MARCH 1961

20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 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 15 MARCH 1961 to DEATH and last saw her/him alive on 15 MARCH 1961
Death occurred at 4:15 AM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Thomas H. Marshall, M.D. 22b. ADDRESS 1325 So. Grand Ave. 22c. DATE SIGNED 3/17/61

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal 23b. DATE 3/18/61 23c. NAME OF CEMETERY OR CREMATORY Mt. Olive 23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.

24. FUNERAL DIRECTOR ADDRESS McLaughlin, 2301 Lafayette(4) 25. DATE RECD. BY LOCAL REG. MAR 17 1961 26. REGISTRAR'S SIGNATURE Loan Smith, M.D.

DATE AMENDED
INSTEAD OF
DOCUMENT
MEDICAL CERTIFICATION
ITEM NO. SHOULD READ
BY AFFIDAVIT OF

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 *H. G. Harris*

Licensed Embalmer No. 7384
P. O. Address *H. G. Harris*

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.

