

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-003706

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **856**

STATE FILE NUMBER

FILED JAN 25 1962

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, Mo.		Length of stay in 1b	c. CITY OR TOWN St. Louis		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Bethesda Hospital		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 823 Wilmington		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Mary Middle E. Last Elchlepp			4. DATE OF DEATH Month Jan. Day 17 Year 1962		
5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Feb. 24, 1889	9. AGE (last birthday) 72	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) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (City and state or country) Arkansas	12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME George Allen		13b. MOTHER'S MAIDEN NAME Rose Ella Cobb		14. NAME OF HUSBAND OR WIFE Fred G. Elchlepp Sr.	
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. unk		17. INFORMANT St. Louis, Mo. Virginia Schmaltz 823 Wilmington	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Generalized adenocarcinoma					2 hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Adenocarcinoma of caecum					2 hrs.
DUE TO (c) 153.0					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I () arterio sclerotic heart disease 1 yr				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	
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 St Louis	
				COUNTY	STATE Mo
21. I attended the deceased from Feb 5 1940 to Jan 17 1962 and last saw her/him alive on Jan 17 1962 Death occurred at 12 noon on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Max Starbuck M.D. (Degree or title)			22b. ADDRESS 519 Dore Place		22c. DATE SIGNED JAN 19 1962
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 1-20-62	23c. NAME OF CEMETERY OR CREMATORY St. Trinity Cem.		23d. LOCATION (City, town, or county) (State) Lemay, Mo.
24. FUNERAL DIRECTOR Southern Funeral Home ADDRESS 6322 S. Grand, St. Louis, Mo.			25. DATE RECD. BY LOCAL REG. JAN 19 1962		26. REGISTRAR'S SIGNATURE Loal Smith M.D.

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Dr. Max Starkloff

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

Samuel C. Dill

Licensed Embalmer No. 4347

P. O. Address 6322 So. Prairie

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.