

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-037513

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9653** STATE FILE NUMBER

FILED OCT 4 1963

DO NOT WRITE ON THIS STUB AMENDED

1. PLACE OF DEATH a. COUNTY - - -		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY - - -	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Missouri</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in 1b <b>9 days</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Faith Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>1018 Market</b>	
3. NAME OF DECEASED (Type or print) First <b>Lora</b> Middle <b>DeLane</b> Last <b>Elledge</b>		4. DATE OF DEATH Month <b>September</b> Day <b>26</b> Year <b>1963</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6-16-18</b>
9. AGE (last birthday) <b>45</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>own home</b>	11. BIRTHPLACE (City and state or country) <b>Frisco, Missouri</b>
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>A. Gardner Ray</b>	
13b. MOTHER'S MAIDEN NAME <b>Mary A. Stark</b>		14. NAME OF HUSBAND OR WIFE <b>William G. Elledge</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.	
17. INFORMANT <b>Mr. William G. Elledge</b>		Address <b>1018 Market St.</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>Coronary artery</b>			INTERVAL BETWEEN ONSET AND DEATH <b>41 8/59</b> <b>9/26/63</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>175.0</b>			
DUE TO (c)			
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
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 <b>4/18/59</b> to <b>9/26/63</b> and last saw her <b>alive</b> on <b>9/26/63</b> Death occurred at <b>12:30 p.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>[Signature]</b>		22b. ADDRESS <b>4652 Maryland</b>	
22c. DATE SIGNED <b>9/27/63</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal-car</b>	23b. DATE <b>9-27-63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dexter Cemetery</b>	
23d. LOCATION (City, town, or county) <b>Dexter, Missouri</b>		23e. REGISTRAR'S SIGNATURE <b>[Signature]</b>	
24. FUNERAL DIRECTOR <b>HOFFMEISTER COLONIAL MORTUARY</b>		25. DATE RECD. BY LOCAL REG. <b>SEP 27 1963</b>	
ADDRESS <b>6464 Chippewa</b>			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
 ITEM NO. SHOULD READ BY AFFIDAVIT OF DOCUMENT  
 1 VS 300  
 2 225  
 3  
 4 1  
 5 1  
 6  
 7 0  
 8 2  
 9  
 10  
 11  
 12 60-0  
 13  
 60  
 USE BLACK INK OR TYPEWRITER RIBBON  
 AMENDED  
 DATA  
 INSTEAD OF  
 MEDICAL CERTIFICATION  
 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 *Eric C. Brannon*

Licensed Embalmer No. 4764

P. O. Address St Louis Mo

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.

Dr. Sol Weisman  
4652 Maryland  
PO. 1-8532

Jan 10 1912