

FILED SEP 8 1941

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 29428

Registration District No. 184

Primary Registration District No. 200

Registrar's No. 1684

PLACE OF DEATH:

(a) County St. Louis  
(b) City or town Carondelet  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Koch Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 30 days  
(Specify whether  
In this community Life  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 96  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4363 St. Louis Avenue  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 7, 1941  
year \_\_\_\_\_ hour 2:30 AM, minute \_\_\_\_\_ P. M.

21. I hereby certify that I attended the deceased from July 1, 1941  
to August 5, 1941  
that I last saw her alive on August 5, 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Pulmonary Tuberculosis Duration 3 yrs.

Due to \_\_\_\_\_

Due to 1341

Other conditions (Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Willard D. Rowland (M. D. or other) A  
Address Koch Hospital Date signed 8-7-41

3. (a) PRINT FULL NAME ELIZABETH SEDRICK

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. unknown

4. Sex F 5. Color or race N 6. (Single) widowed, married, divorced 0

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased 3 - 9 - 19  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
22 4 28 hr. \_\_\_\_\_ min.

9. Birthplace St. Louis MO.  
(City, town, or county) (State or foreign country)

10. Usual occupation Student + NYA work

11. Industry or business \_\_\_\_\_

12. Name James Sedrick

13. Birthplace St. Louis MO.  
(City, town, or county) (State or foreign country)

14. Maiden name Roxanna Crosby

15. Birthplace Arkansas  
(City, town, or county) (State or foreign country)

16. (a) Informant Mother

(b) Address 4363 St. Louis Ave.

17. (a) Burial (b) Date thereof Aug 13 41  
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cemetery

18. (a) Signature of funeral director A. S. Beal United

(b) Address 2726 Lucas Ave

19. (a) AUG 12 1941 (b) E. Mc. Garrison  
(Date received local registrar) (Registrar's signature)

(Licensed Embalmer's Statement on Reverse Side)

SS. 488-12-0172  
WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

**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.....  
....., Registered Apprentice No. ....  
working under my personal supervision.

Signed *Arthur L. Holliard*

Licensed Embalmer No. *4221*

P. O. Address *2649 Delma*

**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 this body is not embalmed, fact should be so stated above.**