

FILED JUN 27 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **21471**
5055

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis 0		a. STATE Missouri	b. COUNTY
c. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Christian Hospital		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Bowling Green	d. STREET ADDRESS (If rural, give location) W.R.

3. NAME OF DECEASED (Type or Print) a. (First) Elizabeth Marie b. (Middle) Mudd c. (Last)			4. DATE OF DEATH (Month) (Day) (Year) 6-7-1949	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 3-1-1915	9. AGE (In years last birthday) 34
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Bowling Green Mo	12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Henry Perk	13b. MOTHER'S MAIDEN NAME Mary Meirsick	14. NAME OF HUSBAND OR WIFE Reginald Mudd
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Reginald Mudd Bowling Green Mo

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bowel Obstruction Peritonitis		
ANTECEDENT CAUSES		DUE TO (b) Ether Anesthesia while undergoing operation for Obstruction of bowel	
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (c) at Christian Hospital	
II. OTHER SIGNIFICANT CONDITIONS		no new stud	
Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Asap	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St Louis Mo 46
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) June 7 49 12:55	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 152X
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **12:55** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Patrick E Taylor Coroner 13	23b. ADDRESS 1300 Clark	23c. DATE SIGNED 6-8-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 6-10-49	24c. NAME OF CEMETERY OR CREMATORY Millwood	24d. LOCATION (City, town, or county) (State) Mo
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DATE REC'D BY LOCAL REG. JUN 10 1949	REGISTRAR'S SIGNATURE J B Sabater	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rowland Mortuary Service
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

5055

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
Student Embalmer

Signed *J. Allen Davis Jr.*
Licensed Embalmer No. *4053*
P. O. Address *St Louis 10 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 this body is not embalmed, fact should be so stated above.