

FILED OCT 27 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35102

State File No. ....

8786

318

1003

Registrar's No. ....

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. ....			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		c. LENGTH OF STAY (in this place) 22 days		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		d. STREET ADDRESS (If rural, give location) 5821 Clemens Ave.			
d. FULL NAME OF HOSPITAL OR INSTITUTION Barnes Hospital,				d. STREET ADDRESS (If rural, give location) 5821 Clemens Ave.					
3. NAME OF DECEASED (Type or Print) a. (First) Ernest		b. (Middle) John		c. (Last) Elgie		4. DATE OF DEATH (Month) (Day) (Year) Oct. 11 1949			
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M.		8. DATE OF BIRTH Sept. 19, 1890		9. AGE (in years last birthday) 59			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bldg. Supt.		10b. KIND OF BUSINESS OR INDUSTRY Western Union		11. BIRTHPLACE (State or foreign country) Ontario, Canada		12. CITIZEN OF WHAT COUNTRY?			
13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Mrs. Irene E. Elgie					
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. 494-01-3197		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Irene E. Elgie, 5821 Clemens Ave.					
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, asthenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH 15 min.	
				I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary embolism					
				ANTECEDENT CAUSES DUE TO (b) Carcinoma of ascending colon					
				Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.					
				DUE TO (c)					
				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION 10.4/49		19b. MAJOR FINDINGS OF OPERATION Carcinoma of ascending colon				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		46			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 152X					
22. I hereby certify that I attended the deceased from Sept. 19, 1949, to Oct. 11, 1949, that I last saw the deceased alive on Oct. 11, 1949, and that death occurred at 10:25 a.m., from the causes and on the date stated above.									
23a. SIGNATURE H. R. Bradley (Degree or title) M.D.				23b. ADDRESS Barnes Hospital,		23c. DATE SIGNED 10/11/49.			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Oct. 11, 1949		24c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.			
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE OCT 13 1949 J. B. Sasater		25. FUNERAL DIRECTOR'S SIGNATURE Arthur J. Donnelly		ADDRESS 3840 Lindell Blvd.					

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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.....

..... Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed.....

*W H Van Matre*

Licensed Embalmer No. ....

*2825*

P. O. Address.....

*4340 Lafayette*

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.