

FILED FEB 24 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **5956**
1413
Registrar's No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 3 - 2725 Watson	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2725 Watson			

3. NAME OF DECEASED (Type or Print) a. (First) Phrona b. (Middle) C c. (Last) Atchison		4. DATE OF DEATH (Month) (Day) (Year) Feb 11, 1950	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Sept. 5, 1871
9. AGE (In years last birthday) 78		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Ill.
		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME Noah Randall	13b. MOTHER'S MAIDEN NAME Ami Liza Kirk	14. NAME OF HUSBAND OR WIFE Deceased
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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. none	17. INFORMANT'S SIGNATURE OR NAME Homer N. Atchison	ADDRESS 2725 Watson
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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 6 days about 10 yrs
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Capillary Bronchitis		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic Endocarditis		
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	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 4214
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?

22. I hereby certify that I attended the deceased from **Jan 18**, 19**50**, to **2/13**, 19**50**, that I last saw the deceased alive on **2/8**, 19**50**, and that death occurred at **8-05 Am.**, from the causes and on the date stated above.

23a. SIGNATURE Theo. F. Auel	(Degree or title) MD - DO	23b. ADDRESS 7465 Hazel, Maplewood Mo	23c. DATE SIGNED 2/12/50
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Feb. 13, 1950	24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Cem.	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.

DATE REC'D BY LOCAL REG. FEB 14 1950	REGISTRAR'S SIGNATURE J. B. Slaughter	25. FUNERAL DIRECTOR'S SIGNATURE M. J. Croghan	ADDRESS 7146 Manchester
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1913

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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 Ronald O. Yohuke

Licensed Embalmer No. 3917

P. O. Address Hawaii, 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.