

FILED NOV 10 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35764

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 2447

1. PLACE OF DEATH a. COUNTY St. Louis			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 Koch		c. LENGTH OF STAY (in this place) 542 days	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2219
d. FULL NAME OF HOSPITAL OR INSTITUTION Robert Koch Hospital			d. STREET ADDRESS (If rural, give location) 3336a Franklin		
3. NAME OF DECEASED (Type or Print) a. (First) Doreen		b. (Middle) Estelle	c. (Last) Love	4. DATE OF DEATH (Month) (Day) (Year) 10-9-50	
5. SEX Fem 3	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single 0	8. DATE OF BIRTH 9-18-30	9. AGE (In years last birthday) 20	IF UNDER 1 YEAR Months Days Hours Min. 21
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Mo 0		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Harold Love		13b. MOTHER'S MAIDEN NAME Lela Kennedy		14. NAME OF HUSBAND OR WIFE	
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. yes	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Record at Robert Koch Hospital		
MEDICAL CERTIFICATION					
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, ashenia, etc. It means the disease, injury, or complication which caused death.			I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Tuberculosis		INTERVAL BETWEEN ONSET AND DEATH 22mos?
			ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c)		
			II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		002X
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			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)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		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 4-15, 1949, to 10-9, 1950, that I last saw the deceased alive on 10-9, 1950, and that death occurred at 3:35 P.M. from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) Harold G. Russell M.D.			23b. ADDRESS Robert Koch Hospital		23c. DATE SIGNED 10-9-50
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 10-11-50	24c. NAME OF CEMETERY OR CREMATORY Boyer Washington		24d. LOCATION (City, town, or county) (State) E. St. Louis, Mo	
DATE REC'D BY LOCAL REG. OCT 11 1950		REGISTRAR'S SIGNATURE R. Romke M.D./mb	25. FUNERAL DIRECTOR'S SIGNATURE C. J. Wash		ADDRESS 3847 Page

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

C. J. Nash

Licensed Embalmer No. *2432*

P. O. Address *3847 Park*

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.