

FILED DEC 27 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 12772  
Registrar's No. 10555

#117440

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 <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis, Missouri</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>2<sup>ND</sup> TOWN St. Louis</u> <u>2229</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>St. Louis City Hospital #1.</u>		d. STREET ADDRESS (If rural, give location) <u>1309 Ohio</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>ETHEL</u> b. (Middle) <u>E.</u> c. (Last) <u>ROSSELOT</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>December 11, 1950</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 22, 1901</u>
9. AGE (In years last birthday) <u>49</u>		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Arkansas</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13a. FATHER'S NAME <u>James A. McCluskey</u>	
13b. MOTHER'S MAIDEN NAME <u>Mary Dolly Huddleston</u>		14. NAME OF HUSBAND OR WIFE <u>Robert F.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Robert F. Rosselot, 1309 Ohio Ave.</u>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cerebral hemorrhage</u> ANTECEDENT CAUSES Morbidity 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.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <u>331X</u>		22. I hereby certify that I attended the deceased from <u>12/9/50</u> to <u>12/11/50</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>12/11/50</u> , 19 <u>50</u> , and that death occurred at <u>2:20am</u> m., from the causes and on the date stated above.	
23a. SIGNATURE <u>John R. Beem, M.D.</u> (Degree or title)		23b. ADDRESS <u>1515 Lafayette Ave.,</u>	
23c. DATE SIGNED <u>12/11/50</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
24b. DATE <u>12-13-50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>	
24d. LOCATION (City, town, or county) (State) <u>Normandy, Mo.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Fred M. Williams, 4535 Washington Blvd</u>	
DATE REC'D BY LOCAL REG. <u>DEC 11 1950</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed.....

*John J. Haines*

Signed.....  
Student Embalmer

Licensed Embalmer No. *4128*

P. O. Address *St. Louis MO*

**Note:** The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

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