

FILED JUN 5 1951

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

18672

State File No. 4722  
Registrar's No.

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

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 OR TOWN St. Louis, Missouri		c. LENGTH OF STAY (In this place) 2099	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1		9 STREET ADDRESS (If rural, give location) 5012 Bulwer 0	
3. NAME OF DECEASED (Type or Print) a. (First) ELEANOR		b. (Middle) THOMAS c. (Last)	
4. DATE OF DEATH (Month) (Day) (Year) MAY 18 1951			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 3	8. DATE OF BIRTH Sept 26 1910.
9. AGE (In years last birthday) 40		10. a. 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) St. Louis Mo	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME John Welsh		13b. MOTHER'S MAIDEN NAME Margaret Kelleher	
14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT'S SIGNATURE OR NAME Margaret Welsh		ADDRESS 5308 N. Kingshighway	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Transverse myelitis	
II. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
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? 342X			
22. I hereby certify that I attended the deceased from 2-22-51, 19__, to 5-18-51, 19__, that I last saw the deceased alive on 5-18-51, 19__, and that death occurred at 10:42 P.M., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) R. Kuwana MD		23b. ADDRESS 1515 Lafayette Avenue	
23c. DATE SIGNED 5-19-51			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 5-22-51	
24c. NAME OF CEMETERY OR CREMATORY Calvary		24d. LOCATION (City, town, or county) (State) St. Louis Mo	
DATE REC'D BY LOCAL REGISTRY MAY 2 1951		REGISTRAR'S SIGNATURE J. B. Pasater	
25. FUNERAL DIRECTOR'S SIGNATURE Sullivan Bros		ADDRESS 2849 N. Euclid Ave	

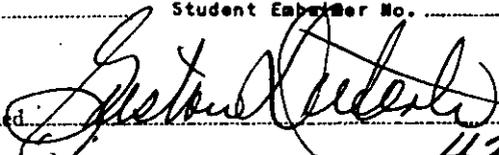
**STATEMENT BY LICENSED EMBALMER**

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 .....  
Student Embalmer

Student Embalmer No. ....

Signed: 

Licensed Embalmer No. 4329

P. O. Address.....

**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.