

FILED SEP 13 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28418
7835

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY /		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Crawford	
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 Leasburg 0280	
c. LENGTH OF STAY (in this place) 11		d. STREET ADDRESS (If rural, give location) /	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4446 Miami			

3. NAME OF DECEASED. (Type or Print) a. (First) Ella b. (Middle) Jane c. (Last) Knight			4. DATE OF DEATH (Month) (Day) (Year) Sept. 3, 1951			
5. SEX / Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married /	8. DATE OF BIRTH Jan. 22, 1875	9. AGE (In years last birthday) 76	IF UNDER 1 YEAR Months Days	IF UNDER 4 HRS. Hours Mts.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Leasburg, Mo. U		12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME James Lewis		13b. MOTHER'S MAIDEN NAME Elizabeth Hamlin		14. NAME OF HUSBAND OR WIFE Harvey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mary Doehring, 4446 Miami St.	

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) <u>Carcinomatous glandular metastases</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Carcinoma of sigmoid colon</u> DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
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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 153 X	

22. I hereby certify that I attended the deceased from July 1949, to Sept 3, 1951, that I last saw the deceased alive on August 19, 1951, and that death occurred at 9:20a. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Thomas W. Parker M.D.		23b. ADDRESS 4660 Maryland		23c. DATE SIGNED 9/4/51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 9-3-51		24c. NAME OF CEMETERY OR CREMATORY Sullivan, Mo.	

DATE REC'D BY LOCAL REG. SEP 4 1951		REGISTRAR'S SIGNATURE Earl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

MAR 9 1954
MAY 17 1954

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 Me

Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed W. W. Wilkins

Licensed Embalmer No. 3575

P. O. Address St. Louis 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.