

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6365

State File No.

~~WED~~ MAR 5 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1531**

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 township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2139	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4305 Maryland Ave. Bernard Nursing Home		d. STREET ADDRESS (If rural, give location) 13 5365 Arsenal St.	

3. NAME OF DECEASED (Type or Print) CATHRYN		a. (First)	b. (Middle)	c. (Last) ELMS	4. DATE OF DEATH (Month) (Day) (Year) Feb. 17 1952		
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	8. DATE OF BIRTH Sep't. 4, 1885	9. AGE (In years last birthday) 66	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 YEAR Hours	IF UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME Frank Seufert	13b. MOTHER'S MAIDEN NAME Frances Schmidt	14. NAME OF HUSBAND OR WIFE Late Charles Elms
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME James E. Elms son	ADDRESS Fergus 341 S. Dade Ave.
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis			2 weeks
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio sclerosis DUE TO (c) Diabetes mellitus			10 yrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			10 years	

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)
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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? 332X
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22. I hereby certify that I attended the deceased from **Feb 5, 1952** to **Feb 17, 1952**, that I last saw the deceased alive on _____, 19____ and that death occurred at **3:30P m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Norman W. Deely MD	23b. ADDRESS 607 N. Grand	23c. DATE SIGNED 2/18/52
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Feb. 20, 1952	24c. NAME OF CEMETERY OR CREMATORY S/S Peter & Paul Cem.	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
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DATE REC'D BY LOCAL REG. FEB 18 1952	REGISTRAR'S SIGNATURE Carl Smith mo	25. FUNERAL DIRECTOR'S SIGNATURE Kriegshauser	ADDRESS 4228 S. Kingshighway Bl.
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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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed William A. White.....

Licensed Embalmer No. 4281.....

P. O. Address 4228 1/2 Kingshigh.....

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.