

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **16661**

FILED APR 29 1953

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500** Registrar's No. **1140**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give RURAL and give township) OR TOWN Rural - St. Ferdinand 6 weeks		c. CITY OR TOWN St. Louis 4000	
d. FULL NAME OF HOSPITAL OR INSTITUTION Halls Gerry Memorial Home		e. STREET ADDRESS (If rural, give location) Halls Gerry Memorial Home 2115 Kapel	
3. NAME OF DECEASED (Type or Print) Ella Recker		4. DATE OF DEATH (Month) (Day) (Year) Apr. 20, 1953	
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Jan. 22, 1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY At Home Retired	
11. BIRTHPLACE (City and State or Foreign Country) Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Thomas Crawford		13b. MOTHER'S MAIDEN NAME Catherine Lyons	
14. NAME OF HUSBAND OR WIFE Deceased			
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. None	
17. INFORMANT'S SIGNATURE OR NAME Christine Boyne		ADDRESS 6561 Avelon Av	
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, ashenia, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart disease 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. Senile Psychosis Malnutrition	
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) (Minute)		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 March 21, 1953 , to April 20, 1953 , that I last saw the deceased alive on April 14, 1953 , and that death occurred at 5:30A m. , from the causes and on the date stated above.			
23a. SIGNATURE Lewis Littmann M.D. (Degree or title)		23b. ADDRESS 8231 Clayton Rd (67)	
23c. DATE SIGNED 4/21/53			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Apr. 22, 1953	
24c. NAME OF CEMETERY OR CREMATORY Calvary		24d. LOCATION (City, town, or county) (State) St. Louis MO.	
DATE REC'D BY LOCAL REG. 4-21-53		REGISTRAR'S SIGNATURE Herbert R. Damb...	
25. FUNERAL DIRECTOR'S SIGNATURE J. J. ...		ADDRESS 1389 Union Blv	

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

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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.....
Signature of Student Embalmer

Signed *Ronald Yahrke*.....
Licensed Embalmer No..... 3970

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.