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FILED AUG 12 1953

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 26289

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 6518

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Louis
c. LENGTH OF STAY (in this place): 1 da
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Desloge Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mo
b. COUNTY: St Louis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Overland
d. STREET ADDRESS (If rural, give location): 2327 Wengler 4 2 1 1

3. NAME OF DECEASED (Type or Print)
a. (First): Bettie
b. (Middle): Ellen
c. (Last): Duncan

4. DATE OF DEATH (Month) (Day) (Year): June 29 1953

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Feb 18 1881
9. AGE (In years last birthday): 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Mo
12. CITIZEN OF WHAT COUNTRY?: USA
13a. FATHER'S NAME: Rudolph Washburn
13b. MOTHER'S MAIDEN NAME: Do not know
14. NAME OF HUSBAND OR WIFE:
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S SIGNATURE OR NAME — ADDRESS: Earl Raney 5832 Tholozan

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Intestinal obstruction — INTERVAL BETWEEN ONSET AND DEATH: about 3 days.

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.
Aspiration pneumonia — 1 day
Cerebral anoxia — 1 day

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

5705

22. *I hereby certify that I attended the deceased from* June 28, 1953, *to* June 29, 1953, *that I last saw the deceased alive on* June 28, 1953, *and that death occurred at* 1:10 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Burnet W. Peden M.D.
23b. ADDRESS: 35 No. Central
23c. DATE SIGNED: 6/29/53

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 1 1953
24c. NAME OF CEMETERY OR CREMATORY: Oak Grove
24d. LOCATION (City, town, or county) (State): St Louis Co Mo

DATE REC'D BY LOCAL REG.: JUN 30 1953
REGISTRAR'S SIGNATURE: J Carl Smith MD
MRS
25. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Ortmann F Home 9222 Lackland Overland Mo

(Licensed Embalmer's Statement on Reverse Side)

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

AUG 12 19

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 Al C Ortmann

Signed.....
Student Embalmer

Licensed Embalmer No. 3478

P. O. Address.....

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.