

FILED AUG 11 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25703

State File No. 1734
Registrar's No. 590

BIRTH NO. _____		REG. DIST. NO. <u>517</u>		PRIMARY REG. DIST. NO. <u>590</u>		Registrar's No. <u>1734</u>	
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived, or institution; residence before death) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Florissant</u>)		c. LENGTH OF STAY (in this place) <u>7 yrs.</u>		c. CITY OR TOWN <u>Florissant</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>1055 Lindsey Lane</u>				e. STREET ADDRESS (If rural, give location) <u>1055 Lindsey La.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Christine</u>			b. (Middle) _____		c. (Last) <u>Atkinson</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>July 17, 1954</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, <u>Widowed</u> (Specify)	8. DATE OF BIRTH <u>Sept. 18, 1872</u>		9. AGE (In years last birthday) <u>71</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 1 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Golconda, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13a. FATHER'S NAME <u>Edward Butler</u>			13b. MOTHER'S MAIDEN NAME <u>Alice Barton</u>		14. NAME OF HUSBAND OR WIFE <u>Robert E. Atkinson</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknowns) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Rowena Stein, Florissant, Mo.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Arteriosclerotic Heart Disease</u>				<u>3 yrs</u>	
		ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Serility</u>				<u>1 year</u>	
		DUE TO (c) _____					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>4200</u>					
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) _____		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 <u>Nov 1953</u> to <u>17 July, 1954</u> , that I last saw the deceased alive on <u>17 July, 1954</u> , and that death occurred at <u>9:25</u> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Marion Bishop MD</u>				23b. ADDRESS <u>757 St Francois Florissant, Mo</u>		23c. DATE SIGNED <u>18 July '54</u>	
24a. BURIAL, CREMATION (REMOVAL) (Specify) <u>Removal</u>		24b. DATE <u>7/19/54</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Garden of Memories</u>		24d. LOCATION (City, town, or county) (State) <u>Sikeston, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>7/19/54</u>		REGISTRAR'S SIGNATURE <u>Robert S. Amke MD</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>White Chapel, Ferguson, Mo.</u>			

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.....
Signature of Student Embalmer

Signed *Eleana Province*

Licensed Embalmer No. *340*

P. O. Address *Jennings*

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.