

FILED SEP 2 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 29020

Registrar's No. 7508

BIRTH NO. 29225-54 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Mo.				c. LENGTH OF STAY (In this place)		c. CITY OR TOWN St. Louis, Mo.	
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>St. Louis Hosp.</i>				d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
e. STREET ADDRESS (If rural, give location) 2609 2609				2508 North 10th.			
3. NAME OF DECEASED (Type or Print)		a. (First) MANDA		b. (Middle) MARIE		c. (Last) KELLOGG	
4. DATE OF DEATH		(Month) August		(Day) 12,		(Year) 1954	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married		8. DATE OF BIRTH May 20, 1954	
9. AGE (In years last birthday)		IF UNDER 1 YEAR Months 2		IF UNDER 24 HRS. Days		IF UNDER 2 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and State or Foreign Country) Washington, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME William Kellog		13b. MOTHER'S MAIDEN NAME Lillian Harris		14. NAME OF HUSBAND OR WIFE Never Married			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS NO. William Kellogg, 2508 North 10th. St. Louis			
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) <i>Suffocation: Cerebral</i>  ANCECEDENT CAUSES <i>Caecal cancer; when struck in the nursing bottle by</i> <i>16 month old brother in the</i> <i>home. Exact date and time</i> <i>unknown</i> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death <i>unknown</i>				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <i>Accident</i>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT (Specify) <i>Accident</i>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Home</i>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <i>St. Louis Mo</i>		21f. HOW DID INJURY OCCUR? <i>E9360</i>	
21d. TIME OF INJURY		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22. I hereby certify that I attended the deceased from <i>Oct 19</i> , 19 <i>54</i> , to <i>Oct 19</i> , 19 <i>54</i> , and that death occurred at <i>10:55 A.M.</i> , from the causes and on the date stated above. <i>22</i>			
23a. SIGNATURE <i>Patrick J. Taylor Crouser</i>		23b. ADDRESS <i>1300 Clark</i>		23c. DATE SIGNED <i>8.13.54</i>			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE August 14, 1954		24c. NAME OF CEMETERY OR CREMATORY St. Trinity		24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri	
DATE REC'D BY LOCAL REG. AUG 13 1954		REGISTRAR'S SIGNATURE <i>J. Carl Smith MD</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>McAughlin Funeral Home, Inc.</i> 2301 Lafayette, St. Louis 4, Missouri.			

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10-48

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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 *James R. Chapman*.....

Licensed Embalmer No. *455*.....

P. O. Address *St. Louis*.....

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.