

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

31650

State File No. ....

8160

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS, MISSOURI</b>		c. LENGTH OF STAY (in this place) <b>22 Days</b>		c. CITY OR TOWN <b>ST. LOUIS, MO.</b>		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 <b>ST. LOUIS CITY HOSPITAL</b>				e. STREET ADDRESS (If rural, give location) <b>23 2644 Park Ave.</b>			
3. NAME OF DECEASED (Type or Print) <b>STELLA</b>			a. (First) _____ b. (Middle) _____ c. (Last) <b>BRISTOW</b>		4. DATE OF DEATH <b>SEPTEMBER 2, 1954</b> (Month) (Day) (Year)		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>April 22, 1893</b>		9. AGE (In years last birthday) <b>61</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 6 HRS. Hours _____ Mins. _____
10a. USUAL OCCUPATION (Give kind of work during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Alex McRenolds</b>			13b. MOTHER'S MAIDEN NAME <b>Annie Zalman</b>		14. NAME OF HUSBAND OR WIFE <b>John</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>John Bristow, 2644 Park Ave., St. Louis, Mo.</b>			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>ADENOCARCINOMA OF UTERUS</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving DUE TO (b) _____ rise to the above cause (a) stating the underlying cause last.  DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH <b>3 YRS</b>
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) (Min) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>174 X</b>			
22. I hereby certify that I attended the deceased from <b>8-11-54</b> , 19____, to <b>9-2-54</b> , 19____, that I last saw the deceased alive on <b>9-2-54</b> , 19____, and that death occurred at <b>9:55A</b> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Richard Thomas Mollis M.D.</b>				23b. ADDRESS <b>1515 Lafayette Avenue</b>		23c. DATE SIGNED <b>9-2-54</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>9-4-1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>St. Matthew's Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri</b>		
DATE REC'D BY LOCAL REG. <b>SEP 4 1954</b>		REGISTRAR'S SIGNATURE <b>J. Earl Smith</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>McLaughlin Funeral Home, Inc. 2301 Lafayette, St. Louis 4, Mo.</b>			

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 *H. G. Farris*.....

Licensed Embalmer No. *338*

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.