

FILED OCT 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35337

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8600**

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		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Baptist Hospital		STREET ADDRESS (If rural, give location) 5455 Delmar 21290	

3. NAME OF DECEASED (Type or Print) a. (First) Herbert b. (Middle) Lee c. (Last) Erskine	4. DATE OF DEATH (Month) (Day) (Year) Sept. 19, 1954
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH Oct. 29, 1917	9. AGE (In years last birthday) 36 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) Agency Owner	10b. KIND OF BUSINESS OR INDUSTRY Advertising	11. BIRTHPLACE (City and State or Foreign Country) Albany, Mo.	12. CITIZEN OF WHAT COUNTRY? U.S.	

13a. FATHER'S NAME Herbert Erskine	13b. MOTHER'S MAIDEN NAME Edna Hutchison	14. NAME OF HUSBAND OR WIFE Unavailable
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME Edna Erskine, Albany, Mo.	ADDRESS
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Asphyxiation by hanging which deceased was found suspended by the neck with a bed sheet from an automatic sprinkler outlet in the ceiling	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. No room at the Missouri Baptist Hospital, all Sept 19, 1954		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death not related to the disease or condition of death. at about 12:15 pm suicide			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION while suffering from temporary mental aberration	20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
21a. ACCIDENT OR SUICIDE (Specify) Suicide	21b. PLACE OF INJURY (e.g., near about home, farm, factory, street, office bldg., etc.) Roop	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis Mo
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Sept 19 54 12:15 pm	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? E974X

22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **12:15 pm**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Patrick Taylor Carson	23b. ADDRESS 1300 Clark	23c. DATE SIGNED 9 20 54
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 9-20-54	24c. NAME OF CEMETERY OR CREMATORY City
24d. LOCATION (City, town, or county) (State) Grandview, Mo.		

DATE REC'D BY LOCAL REG SEP 20 1954	REGISTRAR'S SIGNATURE J. Carl Smith MO	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington Blvd.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1967 26 15

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 *E. J. Peneluna*.....

Licensed Embalmer No. *428*

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.