

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

42340

State File No. ....

FILED DEC 16 1954.

10673

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</b>				c. LENGTH OF STAY (in this place) <b>Life</b>									
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis State Hospital</b>				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b> <span style="float:right">2139</span>									
d. STREET ADDRESS <b>5400 Arsenal St.</b>				e. (If rural, give location) _____									
3. NAME OF DECEASED (Type or Print)		a. (First) <b>ALICE</b>		b. (Middle) <b>---</b>		c. (Last) <b>EBBINGHAUS</b>							
4. DATE OF DEATH		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Never Married</b>							
Nov. 22, 1954.		8. DATE OF BIRTH <b>Sept. 19, 1892</b>		9. AGE (In years last birthday) <b>62</b>		<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td># UNDER 1 YEAR</td> <td># UNDER 2 HRS.</td> </tr> <tr> <td>Months _____</td> <td>Days _____</td> </tr> <tr> <td>Hours _____</td> <td>Min. _____</td> </tr> </table>		# UNDER 1 YEAR	# UNDER 2 HRS.	Months _____	Days _____	Hours _____	Min. _____
# UNDER 1 YEAR	# UNDER 2 HRS.												
Months _____	Days _____												
Hours _____	Min. _____												
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State, or Foreign Country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13a. FATHER'S NAME <b>Herman Ebbinghaus</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>None</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>Unknown</b>		17. INFORMANT'S SIGNATURE OR NAME <b>John Ebbinghaus, 3100 N. Grand Blvd.</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, asthma, etc. It means the disease, injury, or complication which caused death.		<p align="center"><b>MEDICAL CERTIFICATION</b></p> <p>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pubertary Embolus; Fracture (surgically treated) left hip;</b></p> <p>ANTECEDENT CAUSES (b) <b>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <i>suffered a fall caused by being disturbed by a mental patient</i></b></p> <p>II. OTHER SIGNIFICANT CONDITIONS (c) <b>at St. Louis State Hospital, November 2, 1954 at about 3:00 pm</b></p>				INTERVAL BETWEEN ONSET AND DEATH _____							
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <b>Accident</b>		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT (Specify) <b>Accident</b>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Roof</b>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>St. Louis Mo. 000</b>		21f. HOW DID INJURY OCCUR? <b>E9047</b>							
21d. TIME OF INJURY <b>Nov 2 5430 p.m.</b>		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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>130A</b> m., from the causes and on the date stated above. <b>45</b>									
23a. SIGNATURE <b>Satrick Taylor Carauer</b>		23b. ADDRESS <b>1300 Clark</b>		23c. DATE SIGNED <b>11.25.54</b>									
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>11/23/54</b>		24c. NAME OF CEMETERY OR CREMATORY <b>St. Peters Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>							
DATE REC'D BY LOCAL REG. <b>NOV 23 1954</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Calvin F. Feutz, 4828 Natural Bridge Blvd.</b>									

(Licensed Embalmer's Statement on Reverse Side)

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

300  
48

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 .....  
Student Embalmer

Signed Ralph C. Linder

Licensed Embalmer No. 4275

P. O. Address St. Louis, Mo.

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 this body is not embalmed, fact should be so stated above.