

STANDARD CERTIFICATE OF DEATH

FILED FEB 21 1955

State File No. **6126**

BIRTH NO. **4667-55** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1170**

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

1. PLACE OF DEATH a. COUNTY ST. Louis Mo		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) SAINT LOUIS		c. CITY OR TOWN SAINT LOUIS	
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CHILDREN'S		STREET ADDRESS (If rural, give location) 2429 BLOOLE ST	
3. NAME OF DECEASED (Type or Print) a. (First) DEBORAH b. (Middle) JANE c. (Last) ELLIOTT		4. DATE OF DEATH (Month) (Day) (Year) 2-1-55	
5. SEX FEMALE	6. COLOR OR RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH 1-1-55
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 1 IF UNDER 1 YEAR Months Days IF UNDER 1 HR. Hours Min.
11a. FATHER'S NAME FLOYD W. ELLIOTT		11b. MOTHER'S MAIDEN NAME RUTH WEBB	11. BIRTHPLACE (City and State or Foreign Country) ST. Louis, Mo
13a. FATHER'S NAME		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME J. EGAN		ADDRESS 500 S. Kingshighway	
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) Aspiration Pneumonia ANTECEDENT CAUSES: Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cerebral Hypertensive Brain Stain DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION 1/7 & 1/15		19b. MAJOR FINDINGS OF OPERATION Redundant gastric mucosa.	
20. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 31 days	
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 7562	
22. I hereby certify that I attended the deceased from 1-8, 1955 , to 2-1, 1955 that I last saw the deceased alive on 2-1, 1955 , and that death occurred at 6:10 A.M. , from the causes and on the date stated above.			
23a. SIGNATURE Carl Smith (Degree or title)		23b. ADDRESS Children's Hospital	23c. DATE SIGNED 2-2-55
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 2-28-55	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
DATE REC'D BY LOCAL REG. FEB 8 1955	REGISTRAR'S SIGNATURE Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE Rawland Aker ADDRESS 4104 Manchester	

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.....

Licensed Embalmer No.....

P. O. Address.....

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.