

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

10593

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 517 PRIMARY REG. DIST. NO. 500 Registrar's No. 709

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <u>Bel-Nor</u>		c. LENGTH OF STAY (in this place) <u>10/17</u>	c. CITY OR TOWN <u>Pasadena Park</u> <u>4710</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>2848 Moniteau Dr.</u>			e. STREET ADDRESS (If rural, give location) <u>811 North Hills Drive</u>		
3. NAME OF DECEASED (Type or Print) <u>DOLYNE</u>		a. (First)	b. (Middle) <u>---</u>	c. (Last) <u>ELLEFSON</u>	4. DATE OF DEATH (Month) <u>3</u> (Day) <u>26</u> (Year) <u>1955</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 11, 1903</u>	9. AGE (In years last birthday) <u>51</u>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Blythedale, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Cal Scott</u>		13b. MOTHER'S MAIDEN NAME <u>Carrie Cain</u>		14. NAME OF HUSBAND OR WIFE <u>C. O. Ellefson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>493-24-2195</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>C.O. Ellefson, 811 North Hills Dr.</u>			

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of stomach</u>			INTERVAL BETWEEN ONSET AND DEATH <u>9 months</u>
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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	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) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?				

22. I hereby certify that I attended the deceased from Nov 14, 1950, to Mar 26, 1955, that I last saw the deceased alive on Mar 26, 1955, and that death occurred at 3:40 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Robert W. Smith M.D.</u>		23b. ADDRESS <u>114 N. Taylor</u>		23c. DATE SIGNED <u>Mar 28, 1955</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>3/29/55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis County, Mo.</u>		
DATE REC'D BY LOCAL REG. <u>3/28/55</u>	REGISTRAR'S SIGNATURE <u>Heather R. Romberg</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Alvin F. Feutz, 4828 Natural Bridge Blvd.</u>			

(Licensed Embalmer's Placement on Reverse Side)

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

1-10-11

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 *Ralph C. Lindus*

Licensed Embalmer No. *427*

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.