o. 300
0.48

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

FILED MAY 26 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 16963

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 4361

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN: St.Louis
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION: Enroute City Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY
c. CITY OR TOWN: St.Louis
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☐
e. STREET ADDRESS (If rural, give location): 1320 Sullivan Ave. 2260 9 26

3. NAME OF DECEASED (Type or Print)
a. (First): Katherine
b. (Middle): Jennings
c. (Last): Rushing

4. DATE OF DEATH (Month) (Day) (Year): May 17, 1955

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Jan.13,1931
9. AGE (In years last birthday): 24 — 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): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (City and State or Foreign Country): Caruthersville,Mo. 0
12. CITIZEN OF WHAT COUNTRY?: U.S.

13a. FATHER'S NAME: Cecil Jennings
13b. MOTHER'S MAIDEN NAME: Willie Pate
14. NAME OF HUSBAND OR WIFE: Gene Rushing

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT'S SIGNATURE OR NAME: Gene Rushing, ADDRESS: 1320 Sullivan Ave.

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Apoplexy

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Coarctation of the
DUE TO (c): Aorta

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

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 ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 7.5415

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* 415A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Patrick F. Taylor Coroner
23b. ADDRESS: 3/300 Clark
23c. DATE SIGNED: 5.17.55

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 5-17-55
24c. NAME OF CEMETERY OR CREMATORY: Local
24d. LOCATION (City, town, or county) (State): Dexter,Mo.

DATE REC'D BY LOCAL REG.: MAY 17 1955
REGISTRAR'S SIGNATURE: Carl Smith MD
25. FUNERAL DIRECTOR'S SIGNATURE / **ADDRESS**: Albert H. Hoppe 4700 Washington.

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, ~~or by~~ ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Elton H. Remelius

Licensed Embalmer No. 42

P. O. Address St. Lo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
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.