

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 41790

FILED JAN 6 1956

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 11433

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) OR TOWN St. Louis		c. LENGTH OF STAY (In this place)		c. CITY OR TOWN St. Louis	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION D.O.A. Homer G. Phillips Hospital		STREET ADDRESS (If rural, give location) 4220 W Aldine		21190	
3. NAME OF DECEASED (Type or Print) a. (First) ELNORA b. (Middle) McFADDEN c. (Last) BAILEY			4. DATE OF DEATH (Month) (Day) (Year) Dec 25 1955		
5. SEX Female		6. COLOR OR RACE Col		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	
8. DATE OF BIRTH Sept. 22 1890		9. AGE (In years last birthday) 65		10. IF UNDER 1 YEAR: Months 3 Days 3	
11. BIRTHPLACE (City and State or Foreign Country) Fulton, Tenn.		12. CITIZEN OF WHAT COUNTRY? USA			
13a. FATHER'S NAME Noah McFadden		13b. MOTHER'S MAIDEN NAME Elnora Carr		14. NAME OF HUSBAND OR WIFE Finis Bailey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 490-36-5786		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Robert McFadden 4220 W. Aldine	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis		ANTECEDENT CAUSES			
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		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 420.1			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 June 1954, to Dec. 24, 1955, that I last saw the deceased alive on Dec. 24, 1955, and that death occurred at 9:55 P.M., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) Dr. S. Mc Clellan M.D.			23b. ADDRESS 4200 1/2 Easton Ave.		23c. DATE SIGNED 12-28-55
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Dec. 30, 1955	24c. NAME OF CEMETERY OR CREMATORY Greenwood		24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo.
DATE REC'D BY LOCAL REG. DEC 28 1955		REGISTRAR'S SIGNATURE J. Carl Smith MO		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J.H. Randle & Son 3133 Ball Ave	

(Licensed Embalmer's Statement on Reverse Side)

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

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 S J Hato

Licensed Embalmer No. 216

P. O. Address 2749 d

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.