

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25205

State File No.

FILED JUL 20 1956

BIRTH NO.

REG. DIST. NO.

318

PRIMARY REG. DIST. NO.

1003

Registrar's No.

6282

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

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) 2 weeks	c. CITY OR TOWN ST. LOUIS.	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION MO. PAC. HOSP. ST. LOUIS		• STREET ADDRESS (If rural, give location) 608 - A BATES 20190	
3. NAME OF DECEASED (Type or Print) a. (First) ELSIE b. (Middle) HELEN c. (Last) PRICE			4. DATE OF DEATH (Month) (Day) (Year) 7/2/56
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH Dec. 12, 1901
9. AGE (In years last birthday) 54 yrs	IF UNDER 1 YEAR Months Days 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) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Frank Hoey		13b. MOTHER'S MAIDEN NAME Ottillia Stephens	14. NAME OF HUSBAND OR WIFE John C.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME John C. Price
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) CACHEXIA ANTECEDENT CAUSES DUE TO (b) CARCINOMATOSIS ADENOCARCINOMA, DUE TO (c) TRANSVERSE COLON. II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 153x	
19a. DATE OF OPERATION June 22, 55	19b. MAJOR FINDINGS OF OPERATION ADENOCARCINOMA, TRANSVERSE COLON, WITH METASTASIS TO REG. LYMPH NODES.		20. AUTOPSY? YES <input type="checkbox"/> NO <input 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 20, 1955 , to July 2, 1956 , that I last saw the deceased alive on July 2, 1956 , and that death occurred at 3:30pm. , from the causes and on the date stated above.			
23a. SIGNATURE Barth Passencenter M.D.		23b. ADDRESS 1755 So Grand St	23c. DATE SIGNED 7-3-56
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7/5/56	24c. NAME OF CEMETERY OR CREMATORY N. St. Marcus Cem.	24d. LOCATION (City, town, or county) (State) St. Louis Co., Missouri
DATE REC'D BY LOCAL REG. JUL 5 1956	REGISTRAR'S SIGNATURE Charles Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Wacker-Welder ADDRESS 3634 Gravois Ave.	

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. 267
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.