

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35401

FILED OCT 16 1956

State File No.

318

1003

8528

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.		
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) 7 yrs		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 residence-5915 McPherson Ave				e. STREET ADDRESS (If rural, give location) 5915 McPherson Avenue				
3. NAME OF DECEASED (Type or Print) a. (First) Elsie b. (Middle) Linthicum c. (Last) Crist			4. DATE OF DEATH (Month) (Day) (Year) 9 14 56					
5. SEX female		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED Widowed		8. DATE OF BIRTH Sept. 23, 1880		
9. AGE (In years last birthday) 75		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		IF UNDER 1 MIN. Hours		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Farmington, Missouri		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME C. B. Linthicum			13b. MOTHER'S MAIDEN NAME Margaret Pritchett			14. NAME OF HUSBAND OR WIFE Ira H. Crist		
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. 084-09-4828D		17. INFORMANT'S SIGNATURE OR NAME Mrs. Sadie L. Kopp, 5915 McPherson Avenue			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Intestinal obstruction</i>					INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		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. <i>Parent Siley</i>					<i>yes</i>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					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 <u>9-1-</u> , 19 <u>55</u> , to <u>9-13-</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9-13</u> , 19 <u>56</u> and that death occurred at <u>10:00</u> p.m., from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title) <i>M. K. Kimmelman</i>				23b. ADDRESS <i>2906 Union</i>		23c. DATE SIGNED <i>9-14-56</i>		
24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 9-16-56		24c. NAME OF CEMETERY OR CREMATORY Three Rivers Baptist Cem.		24d. LOCATION (City, town, or county) (State) Farmington, Missouri		
DATE REC'D BY LOCAL REG. SEP 15 1956		REGISTRAR'S SIGNATURE <i>Carl Smith MD</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. R. Lupton & Sons-7233 Delmar Blv'd.,				

(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 *Arnold W. Schoene*

Licensed Embalmer No. *3864*

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.