

FILED OCT 24 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36540**
Registrar's No. **2436**

BIRTH NO. _____		REG. DIST. NO. 317		PRIMARY REG. DIST. NO. 544		Registrar's No. 2436	
1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Oregon b. COUNTY Multnomah			
b. CITY (If outside corporate limits, write RURAL and give town) Kirkwood		c. LENGTH OF STAY (in this place) 1 week		c. CITY OR TOWN Gresham.		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Peace Haven - Rott & Geyer Rd				e. STREET ADDRESS (If rural, give location) 435 N.E. Linden Street			
3. NAME OF DECEASED (Type or Print) a. (First) ELIZABETH		b. (Middle) J. Henrietta		c. (Last) LOYD		4. DATE OF DEATH (Month) (Day) (Year) 10 16 56	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Dec. 16, 1884		9. AGE (in years last birthday) 71	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Mins. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired- telephone operator		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME William H. Loyd		13b. MOTHER'S MAIDEN NAME Sadie Helsher		14. NAME OF HUSBAND OR WIFE none			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME Robert J. Loyd, Box 264, Mosier, Oregon			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH 2 yrs 10 yrs -	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) arteriosclerosis		DUE TO (b) Bronchial Asthma			
		* This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c) _____			
		II. OTHER SIGNIFICANT CONDITIONS Saw only 10/10/56. There was evidence of pharyngo-mucous					
19a. DATE OF OPERATION 10/14		19b. MAJOR FINDINGS OF OPERATION On operation		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT SUICIDE HOMICIDE (Specify) suicide		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) home			
21a. TIME OF INJURY (Month) (Day) (Year) (Hour) 11/14 1956		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 1st			
22. I hereby certify that I attended the deceased from 10/14, 1956 , to date , 1956, that I last saw the deceased alive on 10/14, 1956 , and that death occurred at 1:30 P.M. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) D. C. Fodder M.D.				23b. ADDRESS 4140 Forest Park Blvd		23c. DATE SIGNED 10/16/56	
24a. BURIAL, CREMATION, REMOVAL (Specify) cremation		24b. DATE 10-18-1956	24c. NAME OF CEMETERY OR CREMATORY Oak Grove Crematory		24d. LOCATION (City, town, or county) (State) St. Louis County, Missouri		
DATE REC'D BY LOCAL REG. 10-17-56		REGISTRAR'S SIGNATURE Herbert B. Lombardi		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. R. Lupton & Sons-7233 Delmar Blv'd.,			

(Licensed Embalmer's Signature on Reverse Side)

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

No. 300
10.48

87-1-6822.

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1948

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 *Clarence H. Murray*.....

Licensed Embalmer No. *4061*.....

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.