

FILED NOV 28 1956

STANDARD CERTIFICATE OF DEATH

39334

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's **10173**

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, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL #1.			Length of stay in lb 25	d. STREET ADDRESS 1315 N. 7th (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ETTA			First ETTA	Middle	Last DAUDELIN
4. DATE OF DEATH NO. 3, 1956		Month	Day	Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 25, 1880	
9. AGE (In years last birthday) 75		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Missouri	
12. CITIZEN OF WHAT COUNTRY? U.S.			13. FATHER'S NAME Peter Steffan		
14. MOTHER'S MAIDEN NAME Susie Shellhouse			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. Unknown		17. INFORMANT Address James Q. Brown, 8029 Forsythe			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE GASTROINTESTINAL HEMORRHAGE					INTERVAL BETWEEN ONSET AND DEATH 30 Hrs.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) GASTRIC ULCER (GROSSLY BENIGN)					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 540.0					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 11/2/56 6:05 P. to 11/3/56 and last saw ^{her} _{him} alive on 11/3/56 Death occurred at 11:45 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Robert F. Owen, M.D.			22b. ADDRESS 1515 LARAYETTE AVE.		22c. DATE SIGNED 11/5/56
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 11-7-56		23c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory	
23d. LOCATION (City, town, or county) St. Louis Co., Mo.				(State)	
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe, 4700 Washington Blvd.			25. DATE RECD. BY LOCAL REG. NOV 7 1956		26. REGISTRAR'S SIGNATURE Carl Smith mo <i>mjs</i>

(Licensed Embalmer's Statement on Reverse Side)

diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

In Hospital 3 1/2 hrs

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was
by me, or by, Student Embalmer No.
working under my personal supervision..

Student
Signature of Student Embalmer

Signed *J. W. Binkley*
Licensed Embalmer No. *36*

P. O. Address *St. Louis*

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