

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED DEC 30 1957

State File No. **45781**
Registrar's No. **11849**

318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY OR TOWN St. Louis Mo.		c. CITY OR TOWN Appton 48270	
c. LENGTH OF STAY (in this place)		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 St. Louis Childrens Hospital		e. STREET ADDRESS (If rural, give location) 27 7203 Heage Road	
3. NAME OF DECEASED (Type or Print) a. (First) Russell Charles b. (Middle) Ebingen c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) 12-8-57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 1-30-52
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years last birthday) 5 yrs
11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Walter J. Ebingen		13b. MOTHER'S MAIDEN NAME Bernice Smith	14. NAME OF HUSBAND OR WIFE None
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 ADDRESS June Mansfield 500 S. Kingshighway
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic pyelonephritis ANTECEDENT CAUSES DUE TO (b) Nephrocalcinosis DUE TO (c) Oxaluria II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hyperparathyroidism	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 2710	
19c. INTERVAL BETWEEN ONSET AND DEATH 5 yrs.		20. AUTOPSY? YES <input checked="" 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 10-81 , 19 57 , to 12-8 , 19 57 , that I last saw the deceased alive on 12-8 , 19 57 , and that death occurred at 9:40 A.M. , from the causes and on the date stated above.			
23a. SIGNATURE D. R. Thurston		23b. ADDRESS 500 S. Kingshighway	23c. DATE SIGNED 12/8/1957
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE December 11, 1957	24c. NAME OF CEMETERY OR CREMATORY St. Matthews Cemetery	24d. LOCATION (City, town, or county) (State) 4360 Bates St.
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE DEC 10 57	REGISTRAR'S SIGNATURE Earl Smith	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hoffmeister Mortuaries 7814 S. Broadway	

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 *Bill C. Branson*

Licensed Embalmer No. *4764*

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.