

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-037750

STATE FILE NUMBER 9718

FILED OCT 17 1958

Registration District No. \_\_\_\_\_

318

Primary Registration District No. \_\_\_\_\_

1003

Registrar's No. \_\_\_\_\_

300 0  
1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		c. CITY OR TOWN <b>St. Louis</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>		d. STREET ADDRESS (If outside, give location) <b>1435 Newstead</b>	
Length of stay in lb <b>16 Yrs.</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>HOMER NMN ELEY</b>			4. DATE OF DEATH Month Day Year <b>OCTOBER 8, 1958</b>
5. SEX <b>Male 2</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 10, 1899</b>
9. AGE (In years last birthday) <b>59</b>		FUNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Paper Mailer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tension Envelope Co.</b>	11. BIRTHPLACE (City and state or country) <b>Arcadia, Ark.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13a. FATHER'S NAME <b>George Eley</b>	
13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Roxie Eley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No None</b>		16. SOCIAL SECURITY NO. <b>435-28-1259</b>	17. INFORMANT Address <b>Roxie Eley 1435 Newstead</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>POSSIBLE CEREBRAL VASCULAR ACCIDENT</b>			INTERVAL BETWEEN ONSET AND DEATH <b>24 HOURS</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b>			INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>GENERALIZED ARTERIOSCLEROSIS</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 Month, Day, Year a.m. p.m.			
20d. INJURY OCCURRED WHILE AT <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 <b>SEPT. 23, 1958</b> to <b>OCT. 8, 1958</b> and last saw her/him alive on <b>OCT. 8, 1958</b> Death occurred at <b>5:15 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>C. D. Vermillion, M.D.</i> (Degree or title) <b>M. D.</b>		22b. ADDRESS <b>BARNES HOSPITAL</b>	22c. DATE SIGNED <b>10/8/58</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>10/13/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Washington Park Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>
24. FUNERAL DIRECTOR <b>Charles J. Gates</b>	ADDRESS <b>4107 Finney</b>	25. DATE RECD. BY LOCAL REG. <b>OCT 10 '58</b>	26. REGISTRAR'S SIGNATURE <i>J. Carl Smith</i>

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

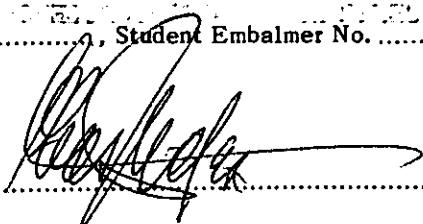
MEDICAL CERTIFICATION

STATE OF MISSISSIPPI  
DEPARTMENT OF HEALTH  
DIVISION OF PUBLIC HEALTH  
1954

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. ....1825.....

P. O. Address ....4107...Finnay...

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.