

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007074

STATE FILE NUMBER

2 1249

FILED FEB 17 1959

Registration District No.

Primary Registration District No.

Registrar's

300
1-57
26
592
0

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 ST. LOUIS, MO.				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN ST. LOUIS, MO.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1.				Length of stay in 1b		d. STREET ADDRESS (If outside, give location) 1112 N. 18th	
3. NAME OF DECEASED (Type or print) First BABY Middle BOY Last ELLISTON				4. DATE OF DEATH Month JAN , Day 6 , Year 1959			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/20/58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (City and state or country) ST. LOUIS MO		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13a. FATHER'S NAME UNKNOWN				13b. MOTHER'S MAIDEN NAME GEORGETTE SILCH		14. NAME OF HUSBAND OR WIFE	
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 Address ST. LOUIS CITY HOSP. #1.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fulminating Colitis Cerebral venous thrombosis 764.0 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (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)						INTERVAL BETWEEN ONSET AND DEATH 7	
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.) Fulminating Colitis				
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.			20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Cerebral Thrombosis (venous)				
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 12/20/58 to 1/6/59 and last saw her/him alive on 1/6/59 Death occurred at 10:40 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Michael S. Ross, M.D.				22b. ADDRESS 1515 LAFAYETTE AVE		22c. DATE SIGNED 1/7/59	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 2-28-59		23c. NAME OF CEMETERY OR CREMATORY Anatomical Board		23d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
24. FUNERAL DIRECTOR Rowland New 4104 Manchester				25. DATE RECD. BY LOCAL REG. FEB 5 59		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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.....

P. O. Address

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.