

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010879

STATE FILE NUMBER

Registration District No. Primary Registration District No.

Registrar's No. **22404**

FILED MAR 20 1959

300
-57
00
054
0

| | | | |
|--|--|--|--|
| 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 | | c. CITY OR TOWN ST. LOUIS | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 3960 a NATURAL BR. | | d. STREET ADDRESS (If outside, give location) 3960a NATURAL BRIDGE | |
| Length of stay in 1b 20 yr. | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

| | | | | | |
|--|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or print) First EMMA Middle E. Last ELDRIDGE | | | 4. DATE OF DEATH Month MARCH Day 5 Year 1959 | | |
|--|--|--|--|--|--|

| | | | | | | |
|-------------------------|----------------------------------|---|--|--|---|-------------------------------|
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH FEB 28 1889 | 9. AGE (In years last birthday) 70yr | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS Hours Min. |
|-------------------------|----------------------------------|---|--|--|---|-------------------------------|

| | | | |
|---|-----------------------------------|---|--|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) ELLENWOOD KANSAS | 12. CITIZEN OF WHAT COUNTRY? USA |
|---|-----------------------------------|---|--|

| | | |
|---|---|--|
| 13a. FATHER'S NAME CARL SCHNEIDER | 13b. MOTHER'S MAIDEN NAME FREDERICKA KRADEL | 14. NAME OF HUSBAND OR WIFE RAYMOND ELDRIDGE SR. |
|---|---|--|

| | | | |
|---|-------------------------------------|--|--|
| 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. — | 17. INFORMANT RAYMOND ELDRIDGE | Address 3960a NATURAL BRIDGE |
|---|-------------------------------------|--|--|

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY Thrombosis | | INTERVAL BETWEEN ONSET AND DEATH 2 days |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Hypertensive Heart disease | 5 years + |
| | DUE TO (c) Hypertension essential | ? |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 420.1 | | 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 1-31-59 to 3-5-59 and last saw her alive on 3-4-59 Death occurred at 11:30 p.m. on the date stated above; and to the best of my knowledge, from the causes stated. |
|--|

| | | |
|---|-------------------------------------|-----------------------------------|
| 22a. SIGNATURE Albert Kaplan M.D. (Degree or title) | 22b. ADDRESS 607 N. Grand | 22c. DATE SIGNED 3-6-59 |
|---|-------------------------------------|-----------------------------------|

| | | | |
|---|----------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | 23b. DATE MARCH 9 1959 | 23c. NAME OF CEMETERY OR CREMATORY NEW BETHLEHEM CEMETERY | 23d. LOCATION (City, town, or county) (State) ST. LOUIS COUNTY MISSOURI |
|---|----------------------------------|---|---|

| | | |
|---|--|---|
| 24. FUNERAL DIRECTOR BEIDERWIEDEN F.H. INC., 1936 ST. LOUIS AVE | 25. DATE RECD. BY LOCAL REG. MAR 9 '59 | 26. REGISTRAR'S SIGNATURE Loan Smith M.D. |
|---|--|---|

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

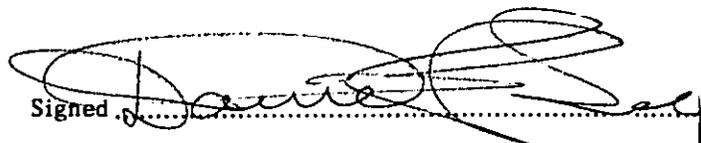
MEDICAL CERTIFICATION

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. 4520
P. O. Address Blair

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.