

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-023570

FILED JUL 3 1959 Registration District No. 317 Primary Registration District No. 531 STATE FILE NUMBER 1746 Registrar's No.

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN University City (30)	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN University City (30)	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (if NOT in hospital, give location) HOSPITAL OR INSTITUTION 7835 Delmar Blvd 10yrs		d. STREET ADDRESS (If outside, give location) 7835 Delmar Blvd	

3. NAME OF DECEASED (Type or print) First ERNEST Middle EDWARD Last BISHOP			4. DATE OF DEATH Month June Day 27 Year 1959			
--	--	--	--	--	--	--

5. SEX Male	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 April 24, 1873	9. AGE (In years last birthday) 86	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) Salesman	10b. KIND OF BUSINESS OR INDUSTRY Illinois Glass Co	11. BIRTHPLACE (City and state or country) Alton, Illinois	12. CITIZEN OF WHAT COUNTRY? USA
--	---	--	--

13a. FATHER'S NAME William H. Bishop	13b. MOTHER'S MAIDEN NAME Mary Frances Purcell	14. NAME OF HUSBAND OR WIFE Ethel E. Bishop
--	--	---

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. 402-10-8858A	17. INFORMANT Address Mrs. Gertrude Ridgeway, 7835 Delmar Bl
---	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS		INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS
GENERALISED ARTERIO SCLEROSIS		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	YEARS
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) MALNUTRITION, SEVERE		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 a.m. p.m.	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> 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 30 APRIL 59 to 27 JUNE 1959 and last saw him alive on 27 JUNE 1959 Death occurred at 9 AM m on the date stated above; and to the best of my knowledge, from the causes stated.	
--	--

22a. SIGNATURE (Degree or title) Roberta Mayer MD	22b. ADDRESS 915 FRANCIS PLACE CLAYTON, MO	22c. DATE SIGNED 6/29/59
---	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE July 1, 1959	23c. NAME OF CEMETERY OR CREMATORY Valhalla Crematory	23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
---	----------------------------------	---	--

24. FUNERAL DIRECTOR Alexander & Sons, 6175 Delmar	25. DATE RECD. BY LOCAL REC. 6-30-59	26. REGISTRAR'S SIGNATURE John C. Murphy MD
--	--	---

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

THIS CERTIFICATE IS PART OF THE DEATH RECORD AND IS NOT TO BE SEPARATED THEREFROM

Dr Robt A Mayer
7509 Wayne
Pa. 7-4916

950 Francis Pl

10 - 1

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 *Jos. E. McCulloch*

Licensed Embalmer No. *9460*

P. O. Address *6175 Dellm*

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.