

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS. JUL 22 1960

5920-60-028477

INDEXED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. _____ STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Mo.		Length of stay in 1b 9 yrs. 6 m. 3 days.	c. CITY OR TOWN St. Louis, Mo.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis State Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 5400 Arsenal Street
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First ELIZABETH Middle Last JELLISON			4. DATE OF DEATH Month June Day 7 Year 1960		
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 10-13-95	9. AGE (last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) formerly: Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) St. Louis, Mo.	12. CITIZEN OF WHAT COUNTRY U.S.	
13a. FATHER'S NAME Thomas Horan		13b. MOTHER'S MAIDEN NAME Elizabeth Byrne		14. NAME OF HUSBAND OR WIFE Seibert Jellison	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) n		16. SOCIAL SECURITY NO. 498-03-4376	17. INFORMANT Address Mr. Seibert Jellison, 407 Lucas Ave.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Recent subdural hematome over lt. cerebellar hemisphere, traumatic		
DUE TO (b) Cerebral edema		
DUE TO (c) Probable fall (no violence)		9047 45

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Esophageal hiatus hernia		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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. Month, Day, Year _____	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 **Dec. 4, 1950** to **June 7, 1960** and last saw her ^{her} _{him} alive on **June 7, 1960**
Death occurred at **2:25 p.m.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Thomas Thak MD	(Degree or title)	22b. ADDRESS 5400 Arsenal St.	22c. DATE SIGNED 6/8/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 6/10/1960	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) St. Louis, Missouri
24. FUNERAL DIRECTOR Alba J. Donnelly	ADDRESS 3840 Lindell Blvd.	25. DATE RECD. BY LOCAL REG. JUN 9 1960	26. REGISTRAR'S SIGNATURE Loan Smith. M.D.

Green Arteriole

DOCUMENT

MEDICAL CERTIFICATION

AFFIDAVIT OF

Revised - Slight Fall Injury

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____ or by _____ Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James Hill

Licensed Embalmer No. 336

P. O. Address 3840

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.