IRI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

FILED VS JAN 9 1961 318 1003 12516 -60-047457

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 12516 STATE FILE NUMBER

NDED

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: St. Louis — Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Homer G. Phillips — Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY
c. CITY OR TOWN: St. Louis — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 4448 Natural Bridge — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First: Debra Middle: Ann Last: Ellis

4. DATE OF DEATH: Month 12 Day 26 Year 60

5. SEX: Female
6. COLOR OR RACE: Negro
7. Married ☐ Never Married ☒ Widowed ☐ Divorced ☐
8. DATE OF BIRTH: May 10.57
9. AGE (last birthday): 3 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HR: Hours, Min.

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: John Ellis Jr
13b. MOTHER'S MAIDEN NAME: Louise Shannon
14. NAME OF HUSBAND OR WIFE: None

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: No
17. INFORMANT: John Ellis Jr Address: 4448 Natural Bridge

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: Undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 490 x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a):
Congestive Heart Failure with Congenital Heart Disease

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
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 ☐ NOT WHILE AT WORK ☐
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 12-5-60, to 12-26-60 and last saw her alive on 12-26-60
Death occurred at 6:25 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE: Parker H. White M.D. (Degree or title)
22b. ADDRESS: 2601 N. Whittier St.
22c. DATE SIGNED: 12-28-60

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal
23b. DATE: 12/29/60
23c. NAME OF CEMETERY OR CREMATORY: Washington Park
23d. LOCATION (City, town, or county) (State): St.Louis County MO

24. FUNERAL DIRECTOR: Boyd Bros ADDRESS: 3706 Finney Ave
25. DATE RECD. BY LOCAL REG.: DEC 28 1960
26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

DOCUMENT

BY AFFIDAVIT OF

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_____ Signed Henry C. Williams
Signature of Student Embalmer

Licensed Embalmer No. 4781

P. O. Address 1205 Walt

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