

FILED JAN 19 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3104

State File No. ....

318

1003

223

BIRTH NO. ....		REG. DIST. NO. ....		PRIMARY REG. DIST. NO. ....		Registrar's No. ....				
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE				b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN		c. LENGTH OF STAY (in this place) TOWNSHIP		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN						
d. FULL NAME OF HOSPITAL OR INSTITUTION				e. STREET ADDRESS (If rural, give location)						
3. NAME OF DECEASED (Type or Print)			a. (First)		b. (Middle)		c. (Last)			
4. DATE OF DEATH			(Month)		(Day)		(Year)			
5. SEX		6. COLOR OR RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH		9. AGE (in years last birthday)		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?				
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME			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)			16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.										
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)						INTERVAL BETWEEN ONSET AND DEATH				
II. OTHER SIGNIFICANT CONDITIONS										
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT (Specify) SUICIDE HOMICIDE		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)			21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from 1-2, 1949, to 1-6, 1949, that I last saw the deceased alive on 1-6, 1949, and that death occurred at 4:50p m., from the causes and on the date stated above.										
23a. SIGNATURE (Degree or title)				23b. ADDRESS			23c. DATE SIGNED			
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State)				
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE			25. FUNERAL DIRECTOR'S SIGNATURE			ADDRESS				

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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.

Signed AD Richardson.....

Signed.....  
Student Embalmer

Licensed Embalmer No. 2928.....

P. O. Address 2625 Glasgow.....

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 this body is not embalmed, fact should be so stated above.