

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

318

1003

6870  
1537

State File No. Registrar's No.

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.	
1. PLACE OF DEATH a. COUNTY <i>Dr Lewis</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <i>Mo</i> b. COUNTY <i>Madison</i>			
b. CITY (If outside corporate limits, write RURAL and give township) <i>Dr Lewis Mo</i>		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) <i>Dr Lewis</i>		17	
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Station</i>				d. STREET ADDRESS (If rural, give location) <i>28 Ark</i>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <i>Walter White Starnes</i>			4. DATE OF DEATH (Month) (Day) (Year) <i>Jan 27 1949</i>				
5. SEX <i>Male</i>	6. COLOR OF SKIN <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>		8. DATE OF BIRTH <i>1887</i>		9. AGE (In years, or under 1 year: first last birth date) (Days) (Hours) (Min.) <i>61 years 1 day</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Wk</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Wk</i>		11. BIRTHPLACE (State or foreign country) <i>Ark</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13a. FATHER'S NAME <i>Wk</i>		13b. MOTHER'S MAIDEN NAME <i>Wk</i>		14. NAME OF HUSBAND OR WIFE <i>Wk</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <i>Wk</i>		16. SOCIAL SECURITY NO. <i>Wk</i>		17. IMPORANT'S SIGNATURE OR NAME <i>Tatlock E. Savin 1300 Clark</i>			
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, asthma, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>EXTERNAL HEMORRAGE, when found</i>				INTERVAL BETWEEN ONSET AND DEATH <i>Jan 27th, 1949 at about 5:45 AM</i>	
		ANTECEDENT CAUSES Morbid conditions, if any, arising DUE TO (b) <i>in a fresh container at Ettrick</i>					
		DUE TO (c) <i>in ladies Rest Room at Union Station</i>					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Jan 27th, 1949 at about 5:45 AM</i>					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <i>Cause and manner could not be determined</i>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <i>E 903</i>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <i>Madison</i>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) <i>11</i>		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 <i>Jan 18</i> , 19 <i>49</i> , to <i>Jan 27</i> , 19 <i>49</i> , that I last saw the deceased alive on <i>Jan 27</i> , 19 <i>49</i> , and that death occurred at <i>Dr Lewis, Mo</i> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <i>Joseph M. Quinn</i>				23b. ADDRESS <i>1300 Clark</i>		23c. DATE SIGNED <i>2/17/49</i>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24b. DATE <i>2-17-49</i>		24c. NAME OF CEMETERY OR CREMATORY <i>City Cemetery</i>		24d. LOCATION (City, town, or county) (State) <i>Dr Lewis Mo</i>	
DATE REC'D BY LOCAL <i>FEB 17 1949</i>		REGISTRAR'S SIGNATURE <i>J. B. Sasser</i>		25. GENERAL DIRECTOR'S SIGNATURE ADDRESS <i>Albert H. Hoppe - 4700 Clarkington</i>			

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

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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 me, or by.....

..... Student Embalmer No. ....

working under my personal supervision.

Signed.....

Signed.....  
Student Embalmer

Licensed Embalmer No.....

P. O. Address.....

**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.