

FILED APR 15 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

10000  
State File No. 3045

318

1003

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)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN					
d. FULL NAME OF (If not in hospital or institution, give street address of location) HOSPITAL OR INSTITUTION				d. 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) IF UNDER 1 YEAR Months Days IF UNDER 4 HRS. Hours Min.		
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 AND 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, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)				INTERVAL BETWEEN ONSET AND DEATH			
				ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.							
				DUE TO (b)							
				DUE TO (c)							
				II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY?			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		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)		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 _____, 1948 to April 2, 1949, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ 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)					
24a. Burial		24b. 3/5/49		24c. Bethlehem Cemetery		24d. St. Louis County Mo.					
DATE REC'D BY LOCAL REG.			REGISTRAR'S SIGNATURE			25. FUNERAL DIRECTOR'S SIGNATURE			ADDRESS		
APR 4 1949			J. D. Fasata			Kraeger-Voss Funeral Home, Inc.					

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

1911 JUN 21

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, ~~as by~~ .....

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

working under my personal supervision.

Student .....  
Student Embalmer

Signed W. W. Wilkinson

Licensed Embalmer No. 3575

P. O. Address St Louis MO

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.