

FILED MAR 19 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 2278  
Registrar's No. 2278

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

6

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Faith Hospital		d. STREET ADDRESS (If rural, give location) 5577 Wells Ave.	

3. NAME OF DECEASED (Type or Print) DAVID			a. (First) b. (Middle) c. (Last) HART			4. DATE OF DEATH Mar. 11, 1949 (Month) (Day) (Year)		
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5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Unknown		9. AGE (In years last birthday) Abt. 42		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner			10b. KIND OF BUSINESS OR INDUSTRY Restaurant			11. BIRTHPLACE (State or foreign country) St. Louis			12. CITIZEN OF WHAT COUNTRY?		
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13a. FATHER'S NAME Phillip Hart			13b. MOTHER'S MAIDEN NAME Ida Joseph			14. NAME OF HUSBAND OR WIFE Lillian Hart		
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Lillian Hart - 5577 Wells Ave.			
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		Pulmonary Tuberculosis Bilat.				?	
		ANTECEDENT CAUSES		Metastatic Carcinoma, Gon.				7/24	
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) Carcinoma, Head Pancreas				1/19	
				DUE TO (c) Duodenal Ulcer, Malignant				12/27	
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.							

19a. DATE OF OPERATION 4/15/47		19b. MAJOR FINDINGS OF OPERATION Gall-Bladder Drainage						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
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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)	
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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?	
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22. I hereby certify that I attended the deceased from 3-15-1946, to 3-15-1949, that I last saw the deceased alive on 3-14-1949, and that death occurred at 8:10 P. M., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Nicholas J. White, M.D.		23b. ADDRESS 3861 St. Louis Ave.		23c. DATE SIGNED 3/11/49	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 3/13/49		24c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri	
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DATE REC'D BY LOCAL REG. MAR 12 1949		REGISTRAR'S SIGNATURE J. B. Foster		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	
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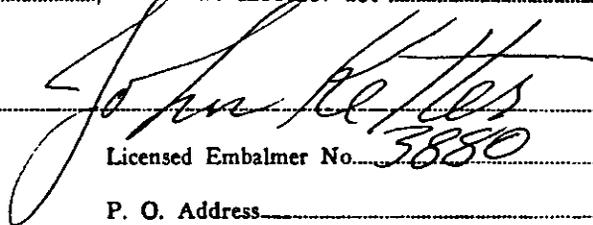
**STATEMENT BY LICENSED EMBALMER**

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.

Student .....  
Student Embalmer

Signed \_\_\_\_\_



Licensed Embalmer No. 3880

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.