

FILED JUN 27 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 21191  
3158 Registrar's No.

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 OR TOWN)				c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township)					
d. FULL NAME OF 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 24 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 OR NAME				ADDRESS	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
<p>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</p>				I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)							
				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) (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 <u>May 15 1949</u> , to <u>June 11 1949</u> that I last saw the deceased alive on <u>June 11, 1949</u> and that death occurred at <u>4:30 pm.</u> , 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 REG.		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.

Student .....  
Student Embalmer

Signed Thomas M. Nelson

Licensed Embalmer No. 4479

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.