

FILED JUL 9 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 21680

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 5651

1. PLACE OF DEATH a. COUNTY b. CITY (If outside corporate limits, write RURAL and give township or TOWN) c. LENGTH OF STAY (in this place) d. FULL NAME OF HOSPITAL OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE b. COUNTY c. CITY (If outside corporate limits, write RURAL and give township or TOWN) 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 OF RACE	7. MARRIED NEVER MARRIED, WIDOWER DIVORCED (Specify)	8. DATE OF BIRTH
9. AGE (In years, if under 1 year, list by month) (Months) (Days)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)
10a.	10b.	11.	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 date of service)		16. SOCIAL SECURITY NO.	17. DECEASED'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.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) 2. ANTECEDENT CAUSES 3. OTHER SIGNIFICANT CONDITIONS	
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, place, etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from _____ to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 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 AND ADDRESS

(Licensed Embalmer's Statement on Reverse Side)

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

8/1

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 Ralph W Henson

Licensed Embalmer No. 2791

P. O. Address St. Louis, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

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