

FILED JUL 30 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

25443

State File No. ....

318

1003

6470

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____ b. CITY OR TOWN <u>Dr. Louis</u> c. LENGTH OF STAY (in this place) _____ d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Bellevue Springs Ave</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>Mo.</u> b. COUNTY _____ c. CITY OR TOWN <u>Dr. Louis</u> d. STREET ADDRESS (If rural give location) _____			
3. NAME OF DECEASED (Type or Print) a. (First) <u>unk</u> b. (Middle) <u>Baby</u> c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u>7 13 49</u>		5. SEX <u>Male</u>		
6. COLOR OR RACE <u>unk</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) _____		8. DATE OF BIRTH <u>unk</u>		9. AGE (In years last birthday) <u>unk</u> 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) <u>unk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>		11. BIRTHPLACE (State or foreign country) <u>unk</u>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <u>unk</u>		13b. MOTHER'S M maiden NAME <u>unk</u>		14. NAME OF HUSBAND OR WIFE <u>unk</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no, if unknown) (If yes, state year or date of service) <u>unk</u>		16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Tamick G. Taylor</u> ADDRESS <u>1300 Clark</u>			
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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>body badly decomposed</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>found in sewer at Bellevue Springs Ave</u> DUE TO (c) <u>about 12:40 July 13, 1949</u> II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u> <u>Homicide at the hands of</u>				INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>Party or Parties unknown</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE <u>Homicide</u>	
21b. PLACE OF INJURY (e.g., to be about home, farm, factory, street, office, etc.) <u>sewer</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Dr. Louis Mo. Ind.</u>		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>7 13 49 12:40</u>			
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>unk</u>					
22. I hereby certify that I attended the deceased from <u>12:40</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>7/13</u> , 19 <u>49</u> , and that death occurred at <u>12:40</u> from the causes and on the date stated above.							
23a. SIGNATURE <u>Joseph M. Quinn</u> (Degree or title) _____				23b. ADDRESS <u>1300 Clark</u>		23c. DATE SIGNED <u>7/26/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE <u>7-26-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>CITY CEMETERY</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis. Mo.</u>	
DATE REC'D BY LOCAL REG. <u>JUL 26 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Foster</u>		FUNERAL DIRECTOR'S SIGNATURE <u>Robert H. Hoffe</u>		ADDRESS <u>4700 Washington</u>	

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.

Student .....  
Student Embalmer

Signed.....

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.