

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

State File No. **28475**  
 Registrar's No. **7167**

FILED AUG 27 1949

**818**

**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 town or township)		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township)		d. STREET ADDRESS (If rural, give location)				
d. FULL NAME OF HOSPITAL OR INSTITUTION										
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)		
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)			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		
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)								
		ANTECEDENT CAUSES								
		DUE TO (b)								
		DUE TO (c)								
		II. OTHER SIGNIFICANT CONDITIONS								
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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 <u>March, 1946</u> , to <u>Aug 16, 1949</u> , that I last saw the deceased alive on <u>Aug 15, 1949</u> , and that death occurred at <u>2 A. m.</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

2912

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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 Van M. Sizemore

Licensed Embalmer No. 4343

P. O. Address. St. Louis 10 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.