

FILED OCT 27 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **35054**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **8678**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		a. STATE <b>Missouri</b> b. COUNTY <b>39</b>	
c. LENGTH OF STAY (in this place) <b>3 mo. 19 days</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Springfield</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis Children's Hospital</b>		d. STREET ADDRESS (If rural, give location) <b>RR-#7 - Box 459</b>	
3. NAME OF DECEASED a. (First) <b>Donald</b> b. (Middle) <b>Lee</b> c. (Last) <b>Decker</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>10-7-49</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <b>Nov-2-1944</b>
9. AGE (In years last birthday) <b>4 yrs. 11 mos.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. <b>11</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Mo.</b>		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME <b>John L. Decker</b>		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	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Myelogenous leukemia, subacute</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" 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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?		<b>2041</b>	
22. I hereby certify that I attended the deceased from <b>6-18, 1949</b> , to <b>10-7, 1949</b> , that I last saw the deceased alive on <b>10-7, 1949</b> , and that death occurred at <b>1:38 p.m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>Wm G Klingberg MD</b>		23b. ADDRESS <b>500 South Kingshighway</b>	
23c. DATE SIGNED <b>10/7/49</b>		24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	
24b. DATE <b>10/7/49</b>		24c. NAME OF CEMETERY OR CREMATORY	
24d. LOCATION (City, town, or county) (State) <b>Springfield, Missouri</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Albert H. Hoppe</b>	
25. ADDRESS <b>4700 Washington</b>		DATE REC'D BY LOCAL REG. <b>OCT 8 1949</b>	

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

**STATEMENT BY LICENSED EMBALMER**

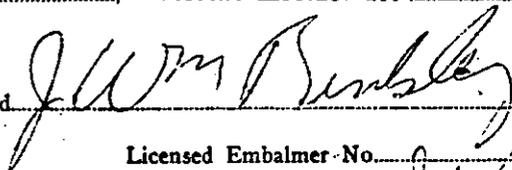
I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed



Licensed Embalmer No. 36153

P. O. Address H. E. M.

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.