

No. 300  
10. 48

FILED OCT 28 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

35248  
9102

State File No. Registrar's No.

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 OR TOWN				c. LENGTH OF STAY (in this place)				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN			
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)			10. 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)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.  I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Intestinal, Vaginal &amp; Resp. tract hemorrhage</i> ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) <i>Acute lymphocytic leukemia</i> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i> INTERVAL BETWEEN ONSET AND DEATH <i>2 mo.</i>											
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) (m.)			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>Oct. 9</u> , 19 <u>49</u> , to <u>Oct 18</u> , 19 <u>49</u> , that I last saw the deceased alive on <u>Oct 18</u> , 19 <u>49</u> , and that death occurred at <u>8:10 P.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

2006

**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 \_\_\_\_\_

*Clare R. Johnson*

Licensed Embalmer No. \_\_\_\_\_

4027

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.