

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39037

State File No. \_\_\_\_\_

FILED NOV 21 1949

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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 OR TOWN)				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN				d. FULL NAME OF HOSPITAL OR INSTITUTION		
c. LENGTH OF STAY (In this place)				d. STREET ADDRESS (If rural, give location)						
3. NAME OF DECEASED 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)				IF UNDER 1 YEAR		IF UNDER 2 HRS.				
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) (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, asthma, etc. It means the disease, injury, or complication which caused death.			MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)						INTERVAL BETWEEN ONSET AND DEATH	
			ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.							
			II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death							
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 checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21f. HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., 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 CREMATOR		24d. LOCATION (City, town, or county) (State)			
DATE REC'D BY LOCAL REG.			REGISTRAR'S SIGNATURE			FUNERAL DIRECTOR'S SIGNATURE ADDRESS				

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

OCT 27 1949

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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 Howard R Rowland

Licensed Embalmer No. 3114

P. O. Address. St Louis, 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.