

FILED JAN 14 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42569

State File No.

11380

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

2092

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

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) b. COUNTY | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address and location) | | d. STREET ADDRESS (If rural, give location) | |
| 3. NAME OF DECEASED (Type or Print) | | 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) Months Days | | 10. AGE (In years last birthday) Months Days | |
| 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 branch 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) _____ ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ 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) (Min.) | | 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 _____, 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 (Deponent 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) | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS | |
| DATE REC'D BY LOCAL REG. REG. JAN 4 1950 | | REGISTRAR'S SIGNATURE | |

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..... *Not Embalmed*

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.