

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JUN 9 1950

#111790

State File No. 17943

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 4790

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Iron</b>	
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis, Mo.</b>		c. CITY (If outside corporate limits, write RURAL and give township) <b>Annapolis</b> <b>0470</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis City Hospital #1.</b>		d. STREET ADDRESS (If rural, give location) <b>1</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>WILLIAM</b>	b. (Middle) <b>H.</b>	c. (Last) <b>ALCORN</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>May 27th, 1950</b>
--	---------------------------	-----------------------	-------------------------	---

5. SEX <b>Male</b> <b>0</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widower</b> <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 16, 1879</b>	9. AGE (In years last birthday) <b>70</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 12 HRS. Hours Min.
--------------------------------	----------------------------------	--	---	--	---	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Blacksmith</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Annapolis, Mo.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
--	-----------------------------------	--	---

13a. FATHER'S NAME <b>John Alcorn</b>	13b. MOTHER'S MAIDEN NAME <b>Sarah Sutton</b>	14. NAME OF HUSBAND OR WIFE <b>Bertha Alcorn</b>
--	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Lyman Alcorn, 3440 Park Ave.</b>	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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Pulmonary tuberculosis, far advanced</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____		
11. 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 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) <b>002-X</b>
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?
---	---	----------------------------

22. I hereby certify that I attended the deceased from 5/26/50 1950, to 5/27/50 1950, that I last saw the deceased alive on 5/27/50 1950, and that death occurred at 7:50 pm, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Robert K. Kyass M.D.</b>	23b. ADDRESS <b>1515 Lafayette Ave.,</b>	23c. DATE SIGNED <b>5/29/50</b>
---	---	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>5-30-50</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Annapolis, Mo.</b>	24d. LOCATION (City, town, or county) (State)
---	-----------------------------	---	---

DATE REC'D BY LOCAL REG. <b>MAY 31 1950</b>	REGISTRAR'S SIGNATURE <b>J. B. Foster</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Albert H. Hoppe, 4700 Washington Blvd.</b>	ADDRESS
--	--	---	---------

(Licensed Embalmer's Statement on Reverse Side)

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

Man

0627

Mr. Graham

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 me

working under my personal supervision.

Student Embalmer No. ....

Signed William S. Smith

Signed.....

Student Embalmer

Licensed Embalmer No. 4699

P. O. Address St. Charles

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.