

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18502

State File No.

4857

318

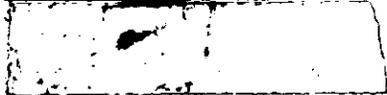
REG. DIST. NO. PRIMARY REG. DIST. NO. 1003 Registrar's No.

BIRTH 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 township) OR TOWN		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN		c. LENGTH OF STAY (In this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year)			
a. (First)		b. (Middle)		c. (Last)	
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 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 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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		INTERVAL BETWEEN ONSET AND DEATH	
20. AUTOPSY? YES <input 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		22. I hereby certify that I attended the deceased from <u>Jan 1948</u> to <u>May 31, 1950</u> , that I last saw the deceased alive on <u>5/31, 1950</u> , and that death occurred at <u>7 P.M.</u> , from the causes and on the date stated above.		23. SIGNATURE (Degree or title)	
23a. SIGNATURE		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)		24e. FUNERAL DIRECTOR'S SIGNATURE		24f. ADDRESS	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24g. FUNERAL DIRECTOR'S SIGNATURE	

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

X



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 *James P. Anderson* _____
Licensed Embalmer No. *4829* _____

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.