

FILED JUL 5 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

21808

State File No. 5534

318

1003

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 township) OR TOWN		c. LENGTH OF STAY (In this place) OR TOWN		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 (First) (Type or Print)		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 (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 ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		Anterior <sup>heart</sup> arteriosclerosis disease		5 mo	
ANTECEDENT CAUSES		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		2 years	
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 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)	
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 Feb 22, 1950, to June 24, 1950, that I last saw the deceased alive on June 22, 1950, and that death occurred at 12:01 p.m. from the causes and on the date stated above.					
23a. SIGNATURE		23b. ADDRESS		23c. DATE SIGNED	
24a. BURIAL OR CREMATION REMOVAL (Specify)		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY	
24d. LOCATION (City, town, or county) (State)					
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE		J. B. Foster		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	
JUN 26 1950				Chas. H. Stuart 1225 Union	

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

*M. E. Gorman*  
*16 Hampton*  
*W. H. Gage*  
*P. H. Gage*

**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 *Clement M. Gage*

Licensed Embalmer No. 3732

P. O. Address St. Louis

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.