

FILED JUL 22 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 25360
6065
REG. DIST. NO. 318
PRIMARY REG. DIST. NO. 1003
Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Lewis	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis - Mo.		c. CITY (If outside corporate limits, write RURAL and give township) Canton 0560	
c. LENGTH OF STAY (in this place) 58 days		d. STREET ADDRESS (If rural, give location) 409 Grant St - 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Children's Hospital			
3. NAME OF DECEASED (Type or Print) a. (First) James b. (Middle) Elmer c. (Last) Tuley		4. DATE OF DEATH (Month) (Day) (Year) July 13 - 1950	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married	8. DATE OF BIRTH Jan - 9 - 1939
9. AGE (in years last birthday) 11 yr	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) LaGrange, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.			
13a. FATHER'S NAME John E. Tuley (deceased)		13b. MOTHER'S MAIDEN NAME Isabel Gibson	
14. NAME OF HUSBAND OR WIFE None			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Isabel Tuley, Canton, Mo.	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Tuberculosis Meningitis 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 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? 010K	
22. I hereby certify that I attended the deceased from 5-17, 1950, to 7-13, 1950, that I last saw the deceased alive on 7-13, 1950, and that death occurred at 9:30 a.m., from the causes and on the date stated above.			
23a. SIGNATURE Wm. Sklunberg M.D.		23b. ADDRESS	
23c. DATE SIGNED			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 7-14-50	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Canton, Mo.
DATE REC'D BY LOCAL REG. JUL 14 1950	REGISTRAR'S SIGNATURE Jr B. S. Sater	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe, 4700 Washington Blvd.	

(Licensed Embalmer's Statement on Reverse Side)

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

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....

William S. Saffers

Signed.....
Student Embalmer

Licensed Embalmer No..... *469*

P. O. Address..... *St Charles, 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.