S. No. 300
v. 10.48

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6-22-VO

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

FILED SEP 9 1950

# THE DIVISION OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 28012

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 6851

**1. PLACE OF DEATH**
a. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Louis City Hospital

**2. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis 2199

d. STREET ADDRESS (If rural, give location): 529 N. Whittier St. 0

**3. NAME OF DECEASED** (Type or Print)
a. (First): James
b. (Middle): Curtis
c. (Last): Bills

**4. DATE OF DEATH** (Month) (Day) (Year): August 11, 1950

**5. SEX**: Male 0
**6. COLOR OR RACE**: White
**7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED** (Specify): Divorced 5
**8. DATE OF BIRTH**: Dec. 15, 1917
**9. AGE** (In years last birthday): 32 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Cab Driver
**10b. KIND OF BUSINESS OR INDUSTRY**: Ace Cab Co.
**11. BIRTHPLACE** (State or foreign country): Holcomb, Mo. 0
**12. CITIZEN OF WHAT COUNTRY?**: U.S.

**13a. FATHER'S NAME**: James Bills
**13b. MOTHER'S MAIDEN NAME**: Mahala Duffer
**14. NAME OF HUSBAND OR WIFE**: Ellen

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If yes, give war or dates of service): Yes World War II
**16. SOCIAL SECURITY NO.**: Unknown
**17. INFORMANT'S SIGNATURE OR NAME** / ADDRESS: John W. Bills, Holcomb, 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): Fr of skull causing subdural

ANTECEDENT CAUSES
*Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Hemorrhage time Peace
cause - Manner of same
DUE TO (c): could not be determined

II. OTHER SIGNIFICANT CONDITIONS
*Conditions contributing to the death but not related to the disease or condition causing death.*

INTERVAL BETWEEN ONSET AND DEATH

**19a. DATE OF OPERATION**
**19b. MAJOR FINDINGS OF OPERATION**: Open Verdict
**20. AUTOPSY?** YES ☑ NO ☐

**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) m.
**21e. INJURY OCCURRED** WHILE AT WORK ☐ NOT WHILE AT WORK ☐
**21f. HOW DID INJURY OCCUR?** 331 X

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* 945A *m., from the causes and on the date stated above.*

**23a. SIGNATURE** (Degree or title): [signature] Coroner
**23b. ADDRESS**: 1300 Clark
**23c. DATE SIGNED**: 8/12/50

**24a. BURIAL, CREMATION, REMOVAL** (Specify): Removal 4
**24b. DATE**: 8-12-50
**24c. NAME OF CEMETERY OR CREMATORY**
**24d. LOCATION** (City, town, or county) (State): Campbell, Mo.

**DATE REC'D BY LOCAL REG.**: AUG 12 1950
**REGISTRAR'S SIGNATURE**: J. B. Lasater
**25. FUNERAL DIRECTOR'S SIGNATURE** / ADDRESS: Albert H. Hoppe, 4700 Washington Blvd.

(Licensed Embalmer's Statement on Reverse Side)

SEP 12 1950

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 Wm L Salfen

Signed.....
Student Embalmer

Licensed Embalmer No. 4699

P. O. Address St. Charles, M

**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.