

FILED OCT 5 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

32250

State File No. _____

Reg. 88013

BIRTH NO. _____		REG. DIST. NO. 317		PRIMARY REG. DIST. NO. 6076		Registrar's No. 2230		
1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____				
b. CITY (If outside corporate limits, write RURAL and give OR TOWN Jeff. Brks. Mo.)		c. LENGTH OF STAY (in this place) 18 days		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2119		
d. FULL NAME OF HOSPITAL OR INSTITUTION VET. ADM. HOSP.				d. STREET ADDRESS (If rural, give location) 4300 St. Ferdinand				
3. NAME OF DECEASED (Type or Print) LE ROY			a. (First)	b. (Middle)	c. (Last) STARKS	4. DATE OF DEATH (Month) (Day) (Year) 9/16/50		
5. SEX M	6. COLOR OR RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 8/10/95		9. AGE (In years last birthday) 55		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Watchman		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? USA		
13a. FATHER'S NAME James Starks			13b. MOTHER'S MAIDEN NAME Suzie (Unk)			14. NAME OF HUSBAND OR WIFE Helen Starks		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. World 1		17. INFORMANT'S SIGNATURE OR NAME V. A. HOSPITAL RECORDS 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, asphyxia, 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) TOXEMIA				ANTECEDENT CAUSES				
*Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUE TO (b) GAS GANGRENE BACILLUS				
DUE TO (c) INFECTION, AMPUTATION LEFT FOOT				II. OTHER SIGNIFICANT CONDITIONS				
Conditions contributing to the death but not related to the disease or condition causing death.				063X				
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify) None		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)		21f. HOW DID INJURY OCCUR?		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) VA		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		063X				
22. I hereby certify that I attended the deceased from 8/30 , 19 50 , to 9/16 , 19 50 , that I had seen the deceased and that death occurred at 4:15 a. m. , from the causes and on the date stated above.								
23a. SIGNATURE [Signature] (Degree or title) M.D.				23b. ADDRESS V.A. HOSP. JEFF. BRKS. MO.		23c. DATE SIGNED 9/17/50		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 9-20-'50		24c. NAME OF CEMETERY OR CREMATORY National Cemetery		24d. LOCATION (City, town, or county) (State) Koch Missouri		
DATE REC'D BY LOCAL REG. SEP 20 1950		REGISTRAR'S SIGNATURE Herbert R. Donke MD		25. FUNERAL DIRECTOR'S SIGNATURE Afflen Dales ADDRESS 3506 Franklin				

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.

Signed.....
Student Embalmer

Signed

Student Embalmer No.

Licensed Embalmer No. 4441

P. O. Address 3506 Franklin

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.