

No. 300  
10.48

FILED 10/17/1950  
REG.# 88031

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 35714

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 2513

1. PLACE OF DEATH a. COUNTY <b>ST. LOUIS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>JEFFERSON BARRACKS, MO.</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS</b>	
c. LENGTH OF STAY (in this place) <b>17 days</b>		d. STREET ADDRESS (If rural, give location) <b>1422 Cole Street(rear)</b>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>VETERANS HOSPITAL</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>NOBLE</b> b. (Middle) <b>(NMI)</b> c. (Last) <b>DRAKE</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>10 - 16 - 1950</b>		
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>8-25-04</b>	9. AGE (In years last birthday) <b>46</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) <b>Waco, Texas</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>

13a. FATHER'S NAME <b>MIKE DRAKE</b>	13b. MOTHER'S MAIDEN NAME <b>MARY ANDERSON</b>	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) <b>Yes WWII</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>
17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>VA HOSPITAL RECORDS, JEFF. BRKS, MO.</b>		

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.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>METASTATIC CARCINOMA OF ESOPHAGUS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>
	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 checked="" 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) <b>VA</b>	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 <b>8-21-1950</b> to <b>10-16-1950</b> , and that death occurred at <b>11:00P</b> m., from the causes and on the date stated above.		

23a. SIGNATURE <b>L.E. Stilwell MD</b>	23b. ADDRESS <b>VA HOSPITAL, JEFFERSON BARRACKS, MO.</b>	23c. DATE SIGNED <b>10-17-50</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>10-20-1950</b>	24c. NAME OF CEMETERY OR CREMATORY <b>NATIONAL</b>
24d. LOCATION (City, town, or county) (State) <b>JEFF. BRKS MO.</b>		

DATE REC'D BY LOCAL REG. <b>10-18-50</b>	REGISTRAR'S SIGNATURE <b>Herbert R. Donke MD</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>WILEY UNDERTAKING COMPANY, St. Louis, Mo</b>
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2502 (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADEING 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 \_\_\_\_\_

*Arvid E. Larsson*

Signed .....  
Student Embalmer

Licensed Embalmer No. *4241*

P. O. Address *St Paul 13. Minn*

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.