

BIRTH NO. 19409-51 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY 0		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo	
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN St. Louis		c. LENGTH OF STAY (In this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION City Hospital # 1		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo. 2269	
		d. STREET ADDRESS (If rural, give location) 1525 N 8th St. 0	

3. NAME OF DECEASED (Type or Print) a. (First) Michael	b. (Middle) Wors.	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) 8-30-51
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5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Child /	8. DATE OF BIRTH 3-4-51	9. AGE (In years last birthday) 5	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	IF UNDER 60 MIN. Min.
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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) St. Louis, Mo. 0	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME John Wors.	13b. MOTHER'S MAIDEN NAME Audrey Hill	14. NAME OF HUSBAND OR WIFE Child
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Mr. John Wors	ADDRESS 1525 N 8th St.
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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)		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Marked Bilateral Obstructasis</u> 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"/>
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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)
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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 1620
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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 4:15 p.m., from the causes and on the date stated above.

23a. SIGNATURE Patrick B. Taylor Coroner	(Degree or title)	23b. ADDRESS 1350 Clark	23c. DATE SIGNED 8/31/51
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 9-1-51	24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Co.
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DATE REC'D BY LOCAL REGISTRY AUG 31 1951	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE Goodhart & Goodhart	ADDRESS 2228 St. Louis, Mo.
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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 J. W. Binkley

Licensed Embalmer No. 3653

Signed.....  
Student Embalmer

P. O. Address.....

**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.