

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

35247

State File No.

FILED NOV 8 1951

318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 9656

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 9656	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MO</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Missouri</u>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS 3229</u>		d. STREET ADDRESS (If rural, give location) <u>1905 HICKORY</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>St. Louis City Hospital #1</u>							
3. NAME OF DECEASED (Type or Print)		a. (First) <u>JOHN</u>		b. (Middle) _____		c. (Last) <u>KEARNS</u>	
4. DATE OF DEATH		(Month) <u>OCT.</u>		(Day) <u>30</u>		(Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>		8. DATE OF BIRTH <u>OCT. 24-1901</u>		9. AGE (In years last birthday) <u>50</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOCK HAND</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>WAREHOUSE</u>		11. BIRTHPLACE (State or foreign country) <u>MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U</u>	
13a. FATHER'S NAME <u>THOMAS KEARNS</u>		13b. MOTHER'S MAIDEN NAME <u>MARY DOONAN</u>		14. NAME OF HUSBAND OR WIFE <u>OLIVE KEARNS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>OLIVE KEARNS</u>			
		(If yes, give war or dates of service)		ADDRESS <u>1905 HICKORY</u>			
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) <u>Lymphoma of nasopharynx</u>				INTERVAL BETWEEN ONSET AND DEATH _____			
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. <u>Gastric Ulcer</u>							
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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? <u>146X</u>			
22. I hereby certify that I attended the deceased from <u>8-3-51</u> , 19 <u> </u> , to <u>10-30-51</u> , 19 <u> </u> , that I last saw the deceased alive on <u>10-30-51</u> , 19 <u> </u> , and that death occurred at <u>11:20Pm.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Robert Thomason M.D.</u>				23b. ADDRESS <u>1515 Lafayette Avenue</u>		23c. DATE SIGNED <u>10-31-9</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>NOV-3-51</u>		24c. NAME OF CEMETERY OR CREMATORY <u>CALVARY</u>		24d. LOCATION (City, town, or county) (State) <u>ST LOUIS MO</u>	
DATE REC'D BY LOCAL REG. <u>NOV 1 1951</u>		REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>E. J. SCHNUR</u>			
				ADDRESS <u>3125 LAFAYETTE</u>			

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed Joe B. Wallmer.....

Licensed Embalmer No. 4014.....

P. O. Address 3125 Lafayette.....

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.