

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39379

State File No.

FILED DEC 15 1951

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10835

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY Adams			
b. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS, MISSOURI		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) Quincy		8124	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL				d. STREET ADDRESS (If rural, give location) 8			
3. NAME OF DECEASED (Type or Print) a. (First) HAROLD		b. (Middle) DAVIS		c. (Last) MC PIKE		4. DATE OF DEATH (Month) (Day) (Year) 12 5 51	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Nov. 15, 1891	
9. AGE (In years last birthday) 60		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 YRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) LaBelle, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13a. FATHER'S NAME Charles McPike		13b. MOTHER'S MAIDEN NAME Lena Ringer		14. NAME OF HUSBAND OR WIFE Frances			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Unknown		17. INFORMANT'S SIGNATURE OR NAME Reba Baron, Peoria, Ill. 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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) EMPYEMA ANTECEDENT CAUSES DUE TO (b) RESECTION OF LEFT LUNG DUE TO (c) PULMONARY TUBERCULOSIS II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 1 WEEK 3 WEEKS 1 YEARS	
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) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? PO 2X			
22. I hereby certify that I attended the deceased from 10/29 , 19 51 , to 12/5 , 19 51 , that I last saw the deceased alive on 12/5 , 19 51 , and that death occurred at 3:40 A m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) C. D. Vermillion, M.D.				23b. ADDRESS BARNES HOSPITAL		23c. DATE SIGNED 12/5/51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 12-6-51		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) LaBelle, Mo.	
DATE REC'D BY LOCAL REG. DEC 6 1951		REGISTRAR'S SIGNATURE J. Carl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe ADDRESS 4800 Washington Blvd.			

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 *John J. Haines*

Licensed Embalmer No. *4408*

P. O. Address *St Louis MO.*

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.