

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH **1003**

State File No. **43033**  
**11303**

FILED JAN 10 1952

**318**

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	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN St. Louis, Missouri)		b. COUNTY Missouri	
c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1		d. STREET ADDRESS (If rural, give location) 5139 Wells	

3. NAME OF DECEASED (Type or Print)	a. (First) DENNIS	b. (Middle)	c. (Last) HOLLAND	4. DATE OF DEATH (Month) (Day) (Year)
				DEC. 12, 1951

5. SEX Male <i>M</i>	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single <i>W</i>	8. DATE OF BIRTH July 5 - 1882	9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Odd jobs	10b. KIND OF BUSINESS OR INDUSTRY Odd jobs	11. BIRTHPLACE (State or foreign country) Ireland 4	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME Michael	13b. MOTHER'S MAIDEN NAME Johanna Sullivan	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown	16. SOCIAL SECURITY NO. Unknown	17. INFORMANT'S SIGNATURE OR NAME Hospital Record	ADDRESS
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) HEMORRHAGE FROM PEPTIC GASTRIC ULCER		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES Morbidity conditions, if any, giving DUE TO (b) rise to the above cause (a) stating the underlying cause last.  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) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>Slipped</i>
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22. I hereby certify that I attended the deceased from 5-19-51, 19\_\_, to 12-12-51, 19\_\_, that I last saw the deceased alive on 12-12-51, 19\_\_, and that death occurred at 10:15A m., from the causes and on the date stated above.

23a. SIGNATURE <i>W. Spencer Payne, M.D.</i> (Degree or title)	23b. ADDRESS 1515 Lafayette Avenue	23c. DATE SIGNED 12-12-51
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL #1	24b. DATE 12-21-51	24c. NAME OF CEMETERY OR CREMATORY CALVARY	24d. LOCATION (City, town, or county) (State) St. Louis MO
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DATE REC'D BY LOCAL REG. DEC 21 1951	REGISTRAR'S SIGNATURE <i>Paul Smith</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Cullum Kelly</i> ADDRESS 4386 Lindell
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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 \_\_\_\_\_

*Students of Mortuary College*

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed *James H. Lammers*

Licensed Embalmer No. *4172*

P. O. Address *St. Louis*

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.