

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

43381

State File No. 11580

FILED JAN 16 1952

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11580

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE <b>Tennessee</b> b. COUNTY <b>Jefferson</b>			
b. CITY (If outside corporate limits, write RURAL and give town) OR TOWN <b>St. Louis, Missouri</b>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Paris</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis City Hospital #1</b>				d. STREET ADDRESS (If rural, give location) _____			
3. NAME OF DECEASED (Type or Print) a. (First) <b>WILLIAM</b>		b. (Middle) _____		c. (Last) <b>TRAVIS</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>DEC. 27, 1951</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Feb-5-1886</b>	
9. AGE (In years last birthday) <b>65</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		9. AGE (In years last birthday) <b>65</b>	
11. BIRTHPLACE (State or foreign country) <b>Paris Tennessee</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Jim Travis</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>	
14. NAME OF HUSBAND OR WIFE <b>Etta Travis</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME <b>May Travis-2311 Lynch St.</b> 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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebrovascular accident</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Cerebral arteriosclerosis</b>  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input 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) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>384X</b>			
22. I hereby certify that I attended the deceased from <b>12-16-51</b> , 19____, to <b>12-27-51</b> , 19____, that I last saw the deceased alive on <b>12-27-51</b> , 19____, and that death occurred at <b>12:48P</b> m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>W. Spencer Payne M.D.</b>				23b. ADDRESS <b>1515 Lafayette Avenue</b>		23c. DATE SIGNED <b>12-27-51</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE _____		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) <b>Paris, Tennessee</b>	
DATE REC'D BY LOCAL HEALTH DEPT. <b>DEC 28 1951</b>		REGISTRAR'S SIGNATURE <b>Paul Smith M.D.</b>		25. GENERAL DIRECTOR'S SIGNATURE <b>Suedmeyer</b> ADDRESS <b>Gov. 3934 N 20th St</b>			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

JAN 8 1964

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.

Signed.....  
Student Embalmer

Signed

*Gustav W. Dickel*

Licensed Embalmer No. *4329*

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.