

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **11232**

S. No. 300  
REV. 10-28-52

ED MAR 19 1952

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **4467** Registrar's No. **363**

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

<b>1. PLACE OF DEATH</b> a. COUNTY <i>St. Louis</i>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, or institution: residence before admission) a. STATE <i>Missouri</i> b. COUNTY <i>St. Louis</i> c. COUNTY <i>4465</i>				
b. CITY OR TOWN <i>Valley Park</i>		c. LENGTH OF STAY (in this place) <i>1 year</i>	c. CITY OR TOWN <i>Richmond Heights</i>				
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>CRP - Mrs. Mack</i>			d. STREET ADDRESS (If rural, give location) <i>7435 Lindbergh Dr</i>				
<b>3. NAME OF DECEASED</b> (Type or Print) <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border: none;">a. (First) <i>Jam</i></td> <td style="width: 33%; border: none;">b. (Middle) <i>Michael</i></td> <td style="width: 33%; border: none;">c. (Last) <i>Heath</i></td> </tr> </table>		a. (First) <i>Jam</i>	b. (Middle) <i>Michael</i>	c. (Last) <i>Heath</i>	<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <i>Feb. 10 1952</i>		
a. (First) <i>Jam</i>	b. (Middle) <i>Michael</i>	c. (Last) <i>Heath</i>					
<b>5. SEX</b> <i>Male</i>	<b>6. COLOR OF RACE</b> <i>White</i>	<b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (Specify) <i>0</i>	<b>8. DATE OF BIRTH</b> <i>May 22 1950</i>	<b>9. AGE</b> (in years last birthday) <i>1 yr.</i>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>	<b>11. BIRTHPLACE</b> (State or foreign country) <i>St. Louis Mo. U</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b>		
<b>13a. FATHER'S NAME</b> <i>Clyde Heath</i>		<b>13b. MOTHER'S MAIDEN NAME</b> <i>Marie Porter</i>		<b>14. NAME OF HUSBAND OR WIFE</b>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, on _____ (date); (If yes, give war or dates of service))		<b>16. SOCIAL SECURITY NO.</b>	<b>17. INFORMANT'S SIGNATURE OR NAME</b> ADDRESS <i>x Clyde E. Heath 7435 Lindbergh</i>				
<b>18. CAUSE OF DEATH</b> Enter only one cause per line for (a), (b), and (c)			<b>MEDICAL CERTIFICATION</b>				
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>acute bronchopneumonia</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>				
ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.			Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <i>Congenital debility</i>				
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.			_____				
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT SUICIDE HOMICIDE</b> (Specify) _____		<b>21b. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	<b>21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)</b> <i>491X</i>		_____		
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) _____		<b>21e. INJURY OCCURRED WHILE AT WORK</b> <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	<b>21f. HOW DID INJURY OCCUR?</b> _____				
<b>22. I hereby certify that I attended the deceased from</b> <i>Sept 15, 1951, to Feb 10, 1952</i> , that I last saw the deceased alive on <i>Feb 9, 1952</i> , and that death occurred at <i>7:30 P. m.</i> , from the causes and on the date stated above.							
<b>23a. SIGNATURE</b> <i>B.R. Loving, M.D.</i> (Degree or title)			<b>23b. ADDRESS</b> <i>Ballwin, Mo.</i>		<b>23c. DATE SIGNED</b> <i>2-11-52.</i>		
<b>24a. BURIAL, CREMATION, REMOVAL</b> (Specify) <i>Burial</i>		<b>24b. DATE</b> <i>Feb 11 1952</i>	<b>24c. NAME OF CEMETERY OR CREMATORY</b> <i>Memorial Park</i>		<b>24d. LOCATION</b> (City, town, or county) (State) <i>St. Louis Mo</i>		
<b>DATE REC'D BY LOCAL REG.</b> <i>2-11-52</i>		<b>REGISTRAR'S SIGNATURE</b> <i>Herbert R. Donkhe M.D.</i>		<b>FUNERAL DIRECTOR'S SIGNATURE</b> ADDRESS <i>Truth Center Mortuary 4024 Lindbergh</i>			

**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.....

Licensed Embalmer No.....

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.