

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **36774**
Registrar's No. **9632**

NOV 12 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) ST. LOUIS		c. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS 2109	
c. LENGTH OF STAY (In this place) 1 DAY		d. STREET ADDRESS (If rural, give location) 4015 Grove ST.	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL			
3. NAME OF DECEASED (Type or Print) a. (First) LEWIS LOUIS b. (Middle) E. c. (Last) RICHARDS		4. DATE OF DEATH (Month) (Day) (Year) 10 18 52	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH Nov. 25, 1873
9. AGE (In years last birthday) 78		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAUNDRYMAN	11. BIRTHPLACE (City and State or Foreign Country) Secor, Ill.
12. CITIZEN OF WHAT COUNTRY? USA		13. NAME OF HUSBAND OR WIFE Katie Richards	
13a. FATHER'S NAME Tom Richards		13b. MOTHER'S MAIDEN NAME HOUSE TRUNNEL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Ms. Katie Richards, 4015 Grove, St. Louis, Mo		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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MASSIVE PNEUMONIA WITH PERIPHERAL VASCULAR COLLAPSE ANTECEDENT CAUSES DUE TO (b) _____ DUE TO (c) _____ Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. II. OTHER SIGNIFICANT CONDITIONS ? GENERALIZED ARTERIOSCLEROSIS NON-TOXIC DIFFUSE NODULAR GOITER	
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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 490x			
22. I hereby certify that I attended the deceased from 10-17 , 19 52 , to 10-18 , 19 52 , that I last saw the deceased alive on 10-18 , 19 52 , and that death occurred at 10:15 a.m. , from the causes and on the date stated above.			
23a. SIGNATURE F. R. Bradley		23b. ADDRESS BARNES HOSPITAL	
(Degree or title) M.D.		23c. DATE SIGNED 10-18-52	
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE 10/21/52	
24c. NAME OF CEMETERY OR CREMATORY SUNSET CEMETERY		24d. LOCATION (City, town, or county) (State) ST. LOUIS COUNTY, MO	
DATE RECD BY LOCAL REG. OCT 20 1952		25. FUNERAL DIRECTOR'S SIGNATURE Bull Campbell Mortuary, 4215 Lindell Blvd	
REGISTRAR'S SIGNATURE J. C. Smith		ADDRESS	

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 Ray C. Campbell

Licensed Embalmer No. 3881

P. O. Address St Louis 8 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.