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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 37043

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 9177

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

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Dr. Louis Mo
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Foot of Adrade

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo.
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Dr Louis
d. STREET ADDRESS (If rural, give location) 28 Wm 4 2008

3. NAME OF DECEASED (Type or Print) a. (First) Wm b. (Middle) White c. (Last) Male

4. DATE OF DEATH (Month) 8 (Day) 24 (Year) 52

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Wm 4
8. DATE OF BIRTH Wh 1882
9. AGE (In years last birthday) 70 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wm
10b. KIND OF BUSINESS OR INDUSTRY Wm
11. BIRTHPLACE (City and State or Foreign Country) Wm 4
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Wm
13b. MOTHER'S MAIDEN NAME Wm
14. NAME OF HUSBAND OR WIFE Wm

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Wm (If yes, give war or dates of service) Wm
16. SOCIAL SECURITY NO. Wm
17. INFORMANT'S SIGNATURE OR NAME F. C. Day 18 1300 Clark 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) _____ INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) _____

DUE TO (c) Chronic Myocarditis

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Decompensated

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

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) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 4222

22. *I hereby certify that I attended the deceased from* _____, 19 7, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* 6 pm *from the causes and on the date stated above.*

23a. SIGNATURE Joseph McQueen Corner (Degree or title)
23b. ADDRESS 1300 Clark
23c. DATE SIGNED 10/1/52

24a. BURIAL, CREMATION, REMOVAL (Specify) 7
24b. DATE 10-3-52
24c. NAME OF CEMETERY OR CREMATORY CITY CEMETERY
24d. LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. OCT 3 1952
REGISTRAR'S SIGNATURE J Carl Smith MD
25. FUNERAL DIRECTOR'S SIGNATURE Albert H Hoppe 4700 Washington ADDRESS

(Licensed Embalmer's Statement on Reverse Side)

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 A. Lammers

Licensed Embalmer No. 4142

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.