

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

State File No. **44015**

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **542** Registrar's No. **3103**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Ferguson		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 919 Robert Ave		d. STREET ADDRESS (If rural, give location) 5016 Robin Ave.	

3. NAME OF DECEASED (Type or Print) a. (First) Joseph b. (Middle) _____ c. (Last) Head		4. DATE OF DEATH (Month) (Day) (Year) Dec. 3 1952	
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Oct. 7, 1884
9. AGE (In years) (Last birthday) 68		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	10b. KIND OF BUSINESS OR INDUSTRY Public Service Co.
11. BIRTHPLACE (City and State or Foreign Country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME James Head	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Lydia Head
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 493-10-8299A	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Clarence A. Head 6031 Lansdowne Ave.

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		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary heart disease		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Coronary occlusion		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		4201	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> 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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Feb 1950**, to **Dec 1st 1952**, that I last saw the deceased alive on **12-1-1952**, and that death occurred at **3:00P** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Norman Miller M.D.	23b. ADDRESS 3903 Park Grills	23c. DATE SIGNED 12-4-52
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Dec. 6, 1952	24c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cem.
24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.		

DATE REC'D BY LOCAL REG. 12-4-52	REGISTRAR'S SIGNATURE Herbert R. Dombke MD	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS G. Hoffmeister Colonial Mortuary 6464 Chippewa St.
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

09

no. 300
0.48

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

Linus C. Hoffmann

Licensed Embalmer No. *3871*

P. O. Address *7814 S. Broadway*

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.