

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2893

0166

FILED JAN 28 1953

318

PRIMARY REG. DIST. NO. 1003

Registrar's No.

0166

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.				
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE				b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township)		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township)		OR TOWN				
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location)						
3. NAME OF DECEASED (Type or Print)		a. (First)		b. (Middle)		c. (Last)		4. DATE OF DEATH (Month) (Day) (Year)		
5. SEX		6. COLOR OR RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH		9. AGE (in years last birthday) Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (City and State or Foreign Country)		12. CITIZEN OF WHAT COUNTRY		
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE				
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 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)						INTERVAL BETWEEN DEATH AND BIRTH	
			ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.							
			DUE TO (b)							
			DUE TO (c)							
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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?					
22. I hereby certify that I attended the deceased from Dec 15, 1952, to Jan 7, 1953, that I last saw the deceased alive on Jan 7, 1953, and that death occurred at 5810 m from the causes and on the date stated above.										
23a. SIGNATURE (Degree or title)				23b. ADDRESS			23c. DATE SIGNED			
24a. BURIAL, CREMATION, OR REMOVAL (Specify)		24b. DATE		24c. NAME OF CEMETERY OR CREMATORIUM		24d. LOCATION (City, town, or county) (State)				
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS					
JAN 7 1953		E. J. Schnur			3125 Lafayette					

WRITE PLAINLY—USING UNFAADING 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

J. B. Williams

Licensed Embalmer No. *2914*
P. O. Address *3125 1/2 Street*

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.