

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FEB 26 1953

318

1003

State File No. 7613

1523

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) OR TOWN		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN	
c. LENGTH OF STAY (in this place) ST. LOUIS		ST. LOUIS 2259	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1716 Cass		d. STREET ADDRESS (If rural, give location) 25 1716 Cass 0	

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) Strayhorn c. (Last) Hart			4. DATE OF DEATH (Month) (Day) (Year) Feb 5, 1953			
5. SEX M	6. COLOR OR RACE Col	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH Mar 19, 1888	9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months 11	IF UNDER 4 HRS. Hours 38
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Ephraim Hart	13b. MOTHER'S MAIDEN NAME Parakee Seales	14. NAME OF HUSBAND OR WIFE Leam
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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.	17. INFORMANT'S SIGNATURE OR NAME William Harris	ADDRESS 4406 West Bell
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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 1 week
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) LOBAR PNEUMONIA		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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) (Min.)	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 2/3, 1953, to 2/5, 1953, that I last saw the deceased alive on 2/5, 1953, and that death occurred at 11:30 P. M., from the causes and on the date stated above.

23a. SIGNATURE Clavis H. Bene, M.D.	(Degree or title)	23b. ADDRESS 205 No. Jefferson	23c. DATE SIGNED 2/7/53
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24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE Feb 10/53	24c. NAME OF CEMETERY OR CREMATORY Oak Dale Cem	24d. LOCATION (City, town, or county) (State) St. Louis MO
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DATE REC'D BY LOCAL REG. FEB 9 1953	REGISTRAR'S SIGNATURE J. Earl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE F. A. Helmer	ADDRESS 4214 Delmar
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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 F. G. Green

Licensed Embalmer No. 2963

P. O. Address 4714 Delmar

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.