

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11479**
2690

FILED MAR 31 1953

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

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

1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, write RURAL and give town or township) OR TOWN St. Louis, Missouri c. LENGTH OF STAY (In this place) _____ d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____ c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis d. STREET ADDRESS (If rural, give location) 1718 S 12th Street	
3. NAME OF DECEASED (Type or Print) JOHN a. (First) _____ b. (Middle) _____ c. (Last) DOUR		4. DATE OF DEATH (Month) (Day) (Year) MARCH 9, 1953	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 15 1904
9. AGE (In years last birthday) 48 If under 1 year: Months _____ Days _____ If under 1 mo.: Hours _____ Min. _____		11. BIRTHPLACE (City and State or Foreign Country) East St Louis Ill	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (City and State or Foreign Country) East St Louis Ill		12. CITIZEN OF WHAT COUNTRY? U S	
13a. FATHER'S NAME John Dour		13b. MOTHER'S MAIDEN NAME Anna Statler	
14. NAME OF HUSBAND OR WIFE Mildred		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 Mildred Dour ADDRESS 1718 S 12th Street	
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized metastatic ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Carcinoma - primary DUE TO (c) lung carcinoma		INTERVAL BETWEEN ONSET AND DEATH _____	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. _____		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
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? 162X	
22. I hereby certify that I attended the deceased from <u>1-16-53</u> , 19 <u>53</u> , to <u>3-9-53</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>3-9-53</u> , 19 <u>53</u> , and that death occurred at <u>8:40A</u> m., from the causes and on the date stated above.			
23a. SIGNATURE Albert E. Stock M.D. (Degree or title)		23b. ADDRESS 1515 Lafayette Avenue	
23c. DATE SIGNED 3-9-53		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24b. DATE 3/11/53		24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	
24d. LOCATION (City, town, or county) (State) St Louis Mo.		25. FUNERAL DIRECTOR'S SIGNATURE Moydell ADDRESS 1926 Allen Av	
DATE REC'D BY LOCAL REG. MAR 10 1953		REGISTRAR'S SIGNATURE J. Carl Smith MD (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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed *Walter E. [Signature]*

Licensed Embalmer No. 4533

P. O. Address *[Signature]*

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.