

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **26852**

FILED JUL 31 1953

318

PRIMARY REG. DIST. NO. **1003**

Registrar's No. **5952**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MO b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, MO 6259	
d. FULL NAME OF HOSPITAL OR INSTITUTION DOA St. Louis Children's Hosp.		d. STREET ADDRESS (If rural, give location) 25 1228 N. 9th St.	

3. NAME OF DECEASED (Type or Print) Daniel Henry Satterfield			4. DATE OF DEATH (Month) (Day) (Year) 6-13-53		
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED NEVER MARRIED WIDOWED DIVORCED (Specify) SINGLE	8. DATE OF BIRTH 6-20-43		9. AGE (In years last birthday) 9
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILD		10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (State or foreign country) ANN ARBOR - MICHIGAN		12. CITIZENSHIP OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Clyton Satterfield		13b. MOTHER'S MAIDEN NAME Fannie Tisdale		14. NAME OF HUSBAND OR WIFE NONE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT'S SIGNATURE OR NAME FANNIE SATTERFIELD ADDRESS 1228 No 9th St	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Respiratory Complications		DUE TO (b) Bulbar Polymyositis		
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		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 checked="" type="checkbox"/> NO <input 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) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 0800

22. I hereby certify that I attended the deceased from 19, to 19, that I last saw the deceased alive on 19, and that death occurred at 1:15 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Dr. L. Hurst	23b. ADDRESS 500 S. Kings Highway	23c. DATE SIGNED 6-13-53
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 6-14-53	24c. NAME OF CEMETERY OR CREMATORY CORNING - ARK.
24d. LOCATION (City, town, or county) (State)		

DATE REC'D BY LOCAL REG. JUN 15 1953	REGISTRAR'S SIGNATURE J. Earl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE Russell Emmert ADDRESS CORNING - ARK.
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(Licensed Embalmer's Statement on Reverse Side)

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.....

Donald O. Yahnke

Licensed Embalmer No. 3917

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.