

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37488**
Registrar's No. **9793**

BIRTH NO. **74421** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY	
b. CITY OR TOWN St. Louis, Missouri		c. CITY OR TOWN St. Louis - 6 2209	
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hospital		d. STREET ADDRESS (If rural, give location) 20 2720^a BENTON STREET	
3. NAME OF DECEASED (Type or Print) a. (First) FLOYD	b. (Middle) H.	c. (Last) PANTER, JR.	4. DATE OF DEATH (Month) (Day) (Year) 10 - 3 - 53
5. SEX MALE	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <input checked="" type="checkbox"/>	8. DATE OF BIRTH 10-3-53
9. AGE (In years last birthday)		10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St. Louis, Missouri
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME FLOYD H. PANTER	13b. MOTHER'S MAIDEN NAME GENEVA FORD	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Hospital Records 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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 10 hours
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity		
	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 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) (Min)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 776X

22. I hereby certify that I attended the deceased from **Oct 3, 1953**, to **Oct 3, 1953**, that I last saw the deceased alive on **Oct 3, 1953**, and that death occurred at **10:25 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Paul K. Webb M.D.	23b. ADDRESS 721 Ohio St. St. Louis Mo	23c. DATE SIGNED 10-5-53
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 10-31-53	24c. NAME OF CEMETERY OR CREMATORY Anatomical Board
24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		

DATE REC'D BY LOCAL REG. OCT 14 1953	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE Rowland ADDRESS 4104 Manchester
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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 J.
Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

✓ If this body is not embalmed, fact should be so stated above.