

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **44676**

FILED DEC 29 1953

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>547</u>		Registrar's No. <u>3186</u>			
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u>				b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Richmond Heights</u>			c. LENGTH OF STAY (In this place) <u>50-yrs.</u>	c. CITY OR TOWN <u>Richmond Heights</u>			d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF HOSPITAL OR INSTITUTION: <u>1450 Rankin Drive</u>				e. STREET ADDRESS (If rural, give location) <u>1450 Rankin Drive</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Dr. Phelps</u>			b. (Middle) <u>G.</u>		c. (Last) <u>Hurford</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 13, 1953</u>		
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>M.</u>		8. DATE OF BIRTH <u>Unk. Unk. 1874</u>		9. AGE (In years last birthday) <u>79</u>	IF UNDER 1 YEAR Months	IF UNDER 12 HRS. Hours	IF UNDER 15 MIN. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physician</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Medicine</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Nebraska</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13a. FATHER'S NAME <u>Thomas Hurford</u>			13b. MOTHER'S MAIDEN NAME <u>Elizabeth Grand</u>			14. NAME OF HUSBAND OR WIFE <u>Mrs. Mary Hurford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Mrs. Mary Hurford, 1450 Rankin Drive</u>				
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) <u>Chronic Myocarditis</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Hypertension Nervous System</u> DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>None of year</u> <u>None of year</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>443 X</u>						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 <u>Dec 2</u> , 19 <u>53</u> , to <u>Dec 13</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>Dec 13</u> , 19 <u>53</u> , and that death occurred at <u>9:30 A.M.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>W. S. Brown MD</u>				23b. ADDRESS <u>3403 Glen</u>		23c. DATE SIGNED <u>12/14/53</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>Dec. 14, 1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>				
DATE REC'D BY LOCAL REG. <u>12/14/53</u>		REGISTRAR'S SIGNATURE <u>Richard B. Somers</u>		FUNERAL DIRECTOR'S SIGNATURE <u>J. Donnelly</u>		ADDRESS <u>840 Lindell Blvd.</u>			

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 me....., Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed [Signature].....
Licensed Embalmer No. 469.....
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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.