

FILED AUG 20 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 29145

BIRTH NO. 48347-54 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 6653

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. LENGTH OF STAY (in this place)				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN							
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS (If rural, give location)											
3. NAME OF DECEASED (Type or Print)			a. (First)			b. (Middle)			c. (Last)			4. DATE OF DEATH (Month) (Day) (Year)			
5. SEX			6. COLOR OR RACE			7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)			8. DATE OF BIRTH			9. AGE (in years last birthday) of UNDER 1 YEAR Months Days			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (City and State or Foreign Country)			12. CITIZEN OF WHAT COUNTRY?						
13a. FATHER'S NAME				13b. MOTHER'S MAIDEN NAME				14. NAME OF HUSBAND OR WIFE							
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				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, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)								INTERVAL BETWEEN ONSET AND DEATH			
				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"/>			
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?				776x			
22. I hereby certify that I attended the deceased from 17 July, 1954, to 19 July 1954 that I last saw the deceased alive on 18 July, 1954, and that death occurred at 3:30 p.m., from the causes and on the date stated above.															
23a. SIGNATURE (Degree or title)				23b. ADDRESS				23c. DATE SIGNED							
24a. BURIAL, CREMATION, REMOVAL (Specify)				24b. DATE				24c. NAME OF CEMETERY OR CREMATORY				24d. LOCATION (City, town, or county) (State)			
DATE REC'D BY LOCAL REG.				REGISTRAR'S SIGNATURE				25. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS			
JUL 19 1954				Charles Smith				Wm Bauermann				Bras Overland			

(Licensed Embalmer's Statement on Reverse Side)

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

*No Embalmer*

**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 *David C. Gibson*

Licensed Embalmer No. *3454*

P. O. Address *Orlando, Fla*

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.