

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED OCT 26 1954

318

REG. DIST. NO. 1003 PRIMARY REG. DIST. NO. Registrar's No. 9477

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| BIRTH NO. _____ | | REG. DIST. NO. 318 | | PRIMARY REG. DIST. NO. 1003 | | Registrar's No. 9477 | |
| 1. PLACE OF DEATH a. COUNTY _____ | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____ | | | |
| b. CITY (If outside corporate limits, write RURAL and give town) St. Louis | | c. LENGTH OF STAY (in this place township) 50yrs | | c. CITY OR TOWN ST. Louis | | 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 in route to Homer Phillips | | | | STREET ADDRESS (If rural, give location) 10 3969 Ashland 210% | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) James | | b. (Middle) _____ | | c. (Last) Dove | | 4. DATE OF DEATH (Month) (Day) (Year) 10-17-54 | |
| 5. SEX Male | | 6. COLOR OR RACE Negro | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | | 8. DATE OF BIRTH 9-13-1903 | |
| 9. AGE (In years last birthday) 51 | | IF UNDER 1 YEAR Months _____ Days _____ | | IF UNDER 24 HRS. Hours _____ Min. _____ | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) Labor | | 10b. KIND OF BUSINESS OR INDUSTRY Labor | | 11. BIRTHPLACE (City and State or Foreign Country) Clarksdale Ark. | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13a. FATHER'S NAME John Dove | | 13b. MOTHER'S MAIDEN NAME Lizzie Dove | | 14. NAME OF HUSBAND OR WIFE Unknown | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) Yes | | 16. SOCIAL SECURITY NO. 726-09-0907 | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS Malissa Hall 2618 N. Taylor Ave. | | | |
| 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, ashenia, etc. It means the disease, injury, or complication which caused death. | | MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Pulmonary Congestion DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cardiac Hypertrophy | | | | INTERVAL BETWEEN ONSET AND 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) _____ | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? 522X | | | |
| 22. I hereby certify that I attended the deceased from 1954 , 19____, that I last saw the deceased live on , 19____, and that death occurred at 9 1/2 m. , from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE Joseph M. Quinn Deputy Registrar (Degree or title) | | | | 23b. ADDRESS 1300 Clark | | 23c. DATE SIGNED 10/18/54 | |
| 24a. BURIAL (CREMATION) REMOVAL (Specify) Burial | | 24b. DATE 10-22-54 | | 24c. NAME OF CEMETERY OR CREMATORY Oakedale | | 24d. LOCATION (City, town, or county) (State) Lemay Mo. | |
| DATE REC'D BY LOCAL REG. OCT 19 1954 | | REGISTRAR'S SIGNATURE J. Quinn | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS A.H. Burks 3506 Franklin | | | |

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.....
Signature of Student Embalmer

Signed.....

John J. Handell

Licensed Embalmer No. *43*

P. O. Address *Wichita*

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.