

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35513**
9212

XC- Filed OCT 26 1954
Reg. #3693
ST #2943

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

Registrar's No. _____

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

1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, write RURAL and give townships) OR TOWN 915 N. Grand, St. Louis, Mo. c. LENGTH OF STAY (In this place) 17 days d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSP.		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Illinois b. COUNTY Madison c. CITY OR TOWN Madison d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> e. STREET ADDRESS (If rural, give location) 1002 Calham Street	
3. NAME OF DECEASED (Type or Print) SIDNEY a. (First) L. b. (Middle) INGRAM c. (Last) 4. DATE OF DEATH (Month) (Day) (Year) October 9, 1954		5. SEX Male 6. COLOR OR RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 8. DATE OF BIRTH 6/5/01 9. AGE (In years last birthday) 53 IF UNDER 1 YEAR Months _____ IF UNDER 1 YEAR Days _____ IF UNDER 1 YEAR Hours _____ IF UNDER 1 YEAR Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) Denver, Tennessee 12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Wayne Sidney 13b. MOTHER'S MAIDEN NAME Willie McCrary 14. NAME OF HUSBAND OR WIFE None		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW-2 16. SOCIAL SECURITY NO. 359-12-2732 17. INFORMANT'S SIGNATURE OR NAME VA HOSP. RECORDS, ST. LOUIS, MO. 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) PULMONARY EDEMA ANTECEDENT CAUSES ACUTE RENAL FAILURE AND DUE TO (b) OVERHYDRATION Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS 36 HOURS	
19a. DATE OF OPERATION 9/22/54 19b. MAJOR FINDINGS OF OPERATION Abdominal Exploration - Appendectomy 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) VA 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 21f. HOW DID INJURY OCCUR? 551X		22. I hereby certify that I attended the deceased from 9/22 , 19 54 , to 10/9 , 19 54 , and that death occurred on the date stated above. and that death occurred at 7:50P m., from the causes and on the date stated above.	
23a. SIGNATURE R. MOCHS (Degree or title) M.D. 23b. ADDRESS VAH, ST. LOUIS, MO. 23c. DATE SIGNED 10-10-54		24a. BURIAL, CREMATION, REMOVAL (Specify) removal 24b. DATE 10-12-54 24c. NAME OF CEMETERY OR CREMATORY Local 24d. LOCATION (City, town, or county) (State) Carbondale, Illinois	
DATE REC'D BY LOCAL REG. OCT 11 1954 REGISTRAR'S SIGNATURE J. Earl Smith M.D. 25. FUNERAL DIRECTOR'S SIGNATURE Russell Und., Co. ADDRESS 2732 Pine Blvd.		_____	

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 *James A. Conte*.....
Licensed Embalmer No.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.