

FILED JAN 18 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43549

State File No. _____

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **11476**

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 township) OR TOWN St. Louis	c. LENGTH OF STAY (in this place) 4 mo. 1 da	c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Chronic Hospital		e. STREET ADDRESS (If rural, give location) 5234 Robert Ave.	

3. NAME OF DECEASED (Type or Print) a. (First) Thomas	b. (Middle) W.	c. (Last) Durham	4. DATE OF DEATH (Month) (Day) (Year) 12-14-54
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M.	8. DATE OF BIRTH Mar 10, 1875
9. AGE (In years last birthday) 79	IF UNDER 1 YEAR Months 9 Days 4	IF UNDER 24 HRS. Hours 4 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stock clerk	10b. KIND OF BUSINESS OR INDUSTRY Shapleigh Hdwre	11. BIRTHPLACE (City and State or Foreign Country) Ky.	12. CITIZEN OF WHAT COUNTRY? U.S.A

13a. FATHER'S NAME Levy Durham	13b. MOTHER'S MAIDEN NAME Nancy Hamilton	14. NAME OF HUSBAND OR WIFE Flora Luckner
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. NO	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Flora Durham 5234 Robert 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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Arteriosclerosis		
	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	
19a. DATE 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) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4500

22. I hereby certify that I attended the deceased from **8-13-**, 19 **54**, to **12-14-54**, 19 **54**, that I last saw the deceased alive on **12-14-54**, 19 **54**, and that death occurred at **5:50 Pm.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Palmer Duane Bowditch MD	23b. ADDRESS 5800 Arsenal Street.	23c. DATE SIGNED 12/15/54
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Dec 18 '54	24c. NAME OF CEMETERY OR CREMATORY Lebanon
24d. LOCATION (City, town, or county) (State) Lebanon, Illinois		

DATE REC'D BY LOCAL REG. DEC 17 1954	REGISTRAR'S SIGNATURE J. Carl Smith MD	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J.L. Ziegenhein & Sons 7027 Gravois A
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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.....
Signature of Student Embalmer

Signed.....
Donald E. Berry

Licensed Embalmer No. *485*

P. O. Address *7027*

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.