

FILED JAN 18 1955

STANDARD CERTIFICATE OF DEATH

State File No. 44099
Registrar's No. 11998

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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)	c. CITY OR TOWN St Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION: Alexian Bros		e. STREET ADDRESS (If rural, give location) 24 3400 Texas 22490	

3. NAME OF DECEASED (Type or Print) a. (First) Ellis b. (Middle) Reinhardt c. (Last) Voyles			4. DATE OF DEATH (Month) (Day) (Year) Dec 31 1954		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH Oct 13 1908	9. AGE (In years last birthday) 46	# UNDER 1 YEAR Months Days # UNDER 1 HR. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman		10b. KIND OF BUSINESS OR INDUSTRY Packing Co		11. BIRTHPLACE (City and State or Foreign Country) Mt Olive Ill	

13a. FATHER'S NAME Menae Voyles		13b. MOTHER'S MAIDEN NAME Marie Sandert		14. NAME OF HUSBAND OR WIFE Bryce Voyles	
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 Mrs Marie Voyles 3400 Texas	

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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Glomerular Nephritis			INTERVAL BETWEEN ONSET AND DEATH 2 years	
		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) 592x		

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?	
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22. I hereby certify that I attended the deceased from April 30, 1952, to Dec 31, 1954, that I last saw the deceased alive on Dec 30, 1954, and that death occurred at 12 Noon, from the causes and on the date stated above.

23a. SIGNATURE B. J. Mc Ginnis M.D.		23b. ADDRESS 76 Hoxeytenkelleys Plgy		23c. DATE SIGNED 1-3-55	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Jan 4 54		24c. NAME OF CEMETERY OR CREMATORY New Pickercous		24d. LOCATION (City, town, or county) (State) St Louis City Mo	
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DATE REC'D BY LOCAL REG. JAN 3 1955		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS E. J. Schnur 3125 Lafayette	
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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.....
Thomas R. Senovic

Licensed Embalmer No. *379*

P. O. Address *3125 Lafa*

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.