

FILED FEB 10 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2456

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 0062

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 town)		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN			
d. FULL NAME OF HOSPITAL OR INSTITUTION		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)		IF UNDER 1 YEAR			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		IF UNDER 24 HRS. Hours Min.			
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)		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)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		Cerebral Arteriosclerosis				6 yrs.	
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused 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.				Diabetes Mellitus	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
		33 4/x				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?			
22. I hereby certify that I attended the deceased from Nov. 1, 1954, to Jan. 3, 1955, that I last saw the deceased alive on Jan. 3, 1955, and that death occurred at 3:00P.m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title)				23b. ADDRESS		23c. DATE SIGNED	
C. S. Vermillion, M.D. O. M. D.				BARNES HOSPITAL		1/3/55	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State)	
removal		1-6-1955		Oak Hill Cemetery		St. Louis Co., Missouri	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
JAN 4 1955		J. Carl Smith MD		G. R. Lupton & Sons; 7233 Delmar Blvd.,			

(Licensed Embalmer's Statement on Reverse Side)

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

MAY 18 1955

FEB 10 1955

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 *Clarence H. Murray*

Licensed Embalmer No. *4011*

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.