

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **9677**
2243

FILED MAR 31 1955

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

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

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1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION D.O.A. City Hospital		d. STREET ADDRESS (If rural, give location) 1710 N. 14th St.	
3. NAME OF DECEASED (Type or Print) a. (First) Orvis		b. (Middle) L.	
c. (Last) Hart		4. DATE OF DEATH (Month) (Day) (Year) March 10 1955	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH February 15, 1894
9. AGE (In years last birthday) 61		IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) Clerk Office		10b. KIND OF BUSINESS OR INDUSTRY Unemployed	
11. BIRTHPLACE (State or foreign country) Fairfield, Illinois		12. CITIZEN OF WHAT COUNTRY? /	
13a. FATHER'S NAME Tip Hart		13b. MOTHER'S MAIDEN NAME Syvrone Hubbard	
14. NAME OF HUSBAND OR WIFE Stella		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW-1	
16. SOCIAL SECURITY NO. WW-1		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Stella Hart 1710 N. 14th St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		MEDICAL CERTIFICATION	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of the Head		INTERVAL BETWEEN ONSET AND DEATH	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		II. OTHER SIGNIFICANT CONDITIONS	
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 Liver Metastasis	
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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 157X		22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 120A m., from the causes and on the date stated above.	
23a. SIGNATURE (Degree or title) Patrick F. Taylor, Coroner		23b. ADDRESS 1300 Clark	
23c. DATE SIGNED 3-11-55		24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	
24b. DATE March 14, 1955		24c. NAME OF CEMETERY OR CREMATORY National Cemetery	
24d. LOCATION (City, town, or county) (State) Jefferson Bks. Mo.		DATE REC'D BY LOCAL REG. MAR 12 1955	
REGISTRAR'S SIGNATURE [Signature]		25 FUNERAL DIRECTOR'S SIGNATURE ADDRESS O. Hoffmeister U. & L. Co. 7814 S. Broadway	

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.....

.....
working under my personal supervision.

Student Embalmer No.....

Signed.....
Student Embalmer

Signed *Harry J. Johnson* as he

Licensed Embalmer No. *2679*

P. O. Address *2814 S. Broadway*

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 this body is not embalmed, fact should be so stated above.