

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **500** Registrar's No. **1980**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MO	
b. CITY (If outside of St. Louis, give city and give town) St. Louis		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Robert Koch Hospital		STREET ADDRESS (If rural, give location) 1623 South 9th Street	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) JOHN	b. (Middle) A. LOGAN	c. (Last) Mc Farlin	(Month) 8	(Day) 24	(Year) 55
5. SEX m	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH 8-13-80		
9. AGE (In years last birthday) 75 yrs			# UNDER 1 YEAR Months	# UNDER 1 YEAR Days	# UNDER 1 YEAR Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Print Press operator		10b. KIND OF BUSINESS OR INDUSTRY Factory		11. BIRTHPLACE (City and State or Foreign Country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
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13a. FATHER'S NAME John Mc Farlin		13b. MOTHER'S MAIDEN NAME Hattie Valley		14. NAME OF HUSBAND OR WIFE Myrtle Knight			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 400-12-4623		17. INFORMANT'S SIGNATURE OR NAME ROBERT KOCH HOSP.		ADDRESS	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
<p>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</p>		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) chronic pulmonary TBC		ANTECEDENT CAUSES far advanced, active		no year + 10 months	
		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 002x		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT (Specify) SUICIDE		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?	
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22. I hereby certify that I attended the deceased from **10-16-1953**, to **8-24-1955**, that I last saw the deceased alive on **8-24-1955**, and that death occurred at **4:45 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE [Signature]		23b. ADDRESS Robert Koch Hospital		23c. DATE SIGNED 8/24/55	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 8/25/55		24c. NAME OF CEMETERY OR CREMATORY Concordia Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis, Missouri	
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DATE REC'D BY LOCAL REG. 8/25/55		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE Chulick Und. Co.		ADDRESS 1722 So. Jefferson	
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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 *Bill C. Branson*.....

Licensed Embalmer No. *476*.....

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.