

FILED OCT 7 - 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **31158**  
**8617**  
Registrar's No. ....

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 <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Jewish Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>14 5816 Nottingham Ave. 21410</b>	
c. LENGTH OF STAY (in this place)		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>CHARLES</b> b. (Middle) <b>CECIL</b> c. (Last) <b>LIKINS</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Sep. 30 1955</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	
8. DATE OF BIRTH <b>Nov. 11, 1895</b>		9. AGE (In years last birthday) <b>59</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Buyer-Beacon Paper Co.</b>	
11. BIRTHPLACE (City and State or Foreign Country) <b>Ash Grove, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		10b. KIND OF BUSINESS OR INDUSTRY	

13a. FATHER'S NAME <b>Charles W. Likins</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Campbell</b>		14. NAME OF HUSBAND OR WIFE <b>Ora Likins</b>	
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes World War I</b>		16. SOCIAL SECURITY NO. <b>486-10-4040</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Ora K. Likins</b> ADDRESS <b>5816 Nottingham Ave.</b>	
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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) <b>Myocardial Infarction</b> ANTECEDENT CAUSES <b>Coronary thrombosis</b> 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. <b>420.1</b>		INTERVAL BETWEEN ONSET AND DEATH	
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19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
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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) m.		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 **Jan 19 53**, to **Sep 30, 19 51**, that I last saw the deceased alive on **Sep 30, 19 55**, and that death occurred at **1:50 P** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Michael W. Karl MD</b>		23b. ADDRESS <b>4152 Maryland</b>		23c. DATE SIGNED <b>10-1-55</b>	
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal (Rail)</b>		24b. DATE <b>10-3-55</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		24d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>	
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DATE REC'D BY LOCAL REG. <b>OCT 3 1955</b>		REGISTRAR'S SIGNATURE <b>J. C. Smith MD</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Kriegshauser</b> ADDRESS <b>4228 S. Kingshighway Bl.</b>	
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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 *W. A. Strauss*.....

Licensed Embalmer No. *453*.....

P. O. Address .....

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.