

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34785

State File No. ....

FILED NOV 15 1955

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BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____				
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 township) OR TOWN				c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN				
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. 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 IF UNDER 1 HR.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (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) (If yes, give war or dates of service)			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	
<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)							
			ANTECEDENT CAUSES							
			DUE TO (b) _____ Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. _____ DUE TO (c) _____							
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION						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) (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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.										
23a. SIGNATURE (Deponent's title)				23b. ADDRESS				23c. DATE SIGNED		
23a. SIGNATURE		23b. ADDRESS		23c. DATE SIGNED						
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State)				
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE			25. FUNERAL DIRECTOR'S SIGNATURE			ADDRESS		

(Licensed Embalmer's Statement on Reverse Side)

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 \_\_\_\_\_

*Not Embalmed*

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed \_\_\_\_\_

*[Handwritten Signature]*

Licensed Embalmer No. *44-7541*

P. O. Address *East St. Louis, Ill.*

**Note:** The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply the above constitutes grounds for revocation of license.)

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