

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39031**
10435
Registrar's No. _____

FILED DEC 12 1955

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 Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS, MISSOURI.		c. LENGTH OF STAY (in this place)	c. CITY OR TOWN St. Louis d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL #1/		e. STREET ADDRESS (If rural, give location) 5 5883 Enright Ave. 20570	

3. NAME OF DECEASED (Type or Print) a. (First) CHARLES b. (Middle) ARTHUR c. (Last) WHITE			4. DATE OF DEATH (Month) (Day) (Year) NOVEMBER 24, 1955.		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) SINGLE	8. DATE OF BIRTH DEC. 1 1891	9. AGE (In years last birthday) 63	if UNDER 1 YEAR Days if UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work of working life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (City and State or Foreign Country) ILL. /	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME JESSE WHITE	13b. MOTHER'S MAIDEN NAME LINDA	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) unknown	16. SOCIAL SECURITY NO. unknown	17. INFORMANT'S SIGNATURE OR NAME ADDRESS City Hospital Records St. Louis, Mo.
---	--	---

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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Thrombosis Cerebral Vessel		INTERVAL BETWEEN ONSET AND DEATH 3 wks.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) 3 wks.		
	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 332X	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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?
--	--	----------------------------

22. I hereby certify that I attended the deceased from **10-26** 19**55**, to **11-24**, 19**55**, that I last saw the deceased alive on **11-24**, 19**55**, and that death occurred at **6:15p** m., from the causes and on the date stated above.

23a. SIGNATURE James W. Harley M.D. (Degree or title)	23b. ADDRESS 1515 LAFAYETTE AVE.	23c. DATE SIGNED 11-25-55.
--	---	-----------------------------------

24a. BURIAL, CREMATION REMOVAL (Specify) cremation	24b. DATE 12-6-55	24c. NAME OF CEMETERY OR CREMATORY City Crematory	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
---	--------------------------	--	---

DATE REC'D BY LOCAL REG. NOV 30 1955	REGISTRAR'S SIGNATURE Paul Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe 4700 Washington Blvd.
---	--	---

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.....
Not embalmed
Larry Meyer

Licensed Embalmer No.....

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.