

FILED NOV 26 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **39776**
Registrar's No. **9241**

318 PRIMARY REG. DIST. NO. 1003

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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) | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) | | | | c. LENGTH OF STAY (in this place) | | c. CITY OR TOWN | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION | | | | e. 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 (In years last birthday) (Months) (Days) (Hours) (Min.) | | 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 9b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (City and State or Foreign Country) | |
| 10a. USUAL OCCUPATION | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE | | 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) *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) | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | ANTECEDENT CAUSES 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. | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 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) | | 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 9/11, 1936 to 10/8, 1956, that I last saw the deceased alive on 10/9, 1956, and that death occurred at 10:45 P.M., from the causes and on the date stated above. | | | | | | | |
| 23a. SIGNATURE (Degree or title) | | | | 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 | |

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

OCT 10 1956
 [Signature]
 [Signature]
 (Licensed Embalmer's Statement on Reverse Side)

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..... *Homer V. Fritz*

Licensed Embalmer No. *388*

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.