

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44089

FILED DEC 27 1956

State File No.

318

1003

11059

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>ILLINOIS</u> b. COUNTY <u>Williamson</u>	
b. CITY (If outside corporate limits, write RURAL and give town or township) <u>St. Louis, Missouri.</u>	c. LENGTH OF STAY (in this place) <u>5 days</u>	c. CITY OR TOWN <u>HURST</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>MO. PAC. EMP. HOSP. ASSN.</u>		f. STREET ADDRESS (If rural, give location) <u>8128</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>JOHN</u> b. (Middle) <u>ALLEN</u> c. (Last) <u>WHITE</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>DEC 1 1956</u>					
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>FEB. 14, 1889</u>	9. AGE (In years last birthday) <u>67</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SWITCHMAN</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>RAILROAD</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Murphysboro, Illinois</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			

13a. FATHER'S NAME <u>Frank White</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>LILLIAN (WIFE)</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No Nil</u>	16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Lillian White, Hurst, Illinois.</u>

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, asthenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Medical Certification</u> <u>Broncho pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u> <u>3 wks</u> <u>many years</u> <u>3 days</u>
	ANTECEDENT CAUSES DUE TO (b) <u>Congestive heart failure</u> DUE TO (c) <u>Arteriosclerosis</u>		
	11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Wremia 4500</u>		

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 11-26, 1956, to 12-1, 1956, that I last saw the deceased alive on 11/30/56, 1956, and that death occurred at 5a. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Donald E. West M.D.</u>	23b. ADDRESS <u>4909 Lindenwood</u>	23c. DATE SIGNED <u>12-1-56</u>
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE <u>12-1-56</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Tower Grove Cemetery</u>
		24d. LOCATION (City, town, or county) (State) <u>Murphysboro, Illinois.</u>

DATE REC'D BY LOCAL REG. <u>DEC 3 1956</u>	REGISTRAR'S SIGNATURE <u>Carl Smith M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <input checked="" type="checkbox"/> <u>Albert H. Hoppe, 4700 Washington Blvd.,</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

0.300
0.48

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 *John J. Haines*
Licensed Embalmer No. *410*

P. O. Address *Shelby, Va*

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.