

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED APR 15 1957

State File No. **10132**  
**2849**  
Registrar's No.

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>2849</b>	
1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>			
b. CITY (If outside corporate limits, write RURAL and give township) <b>St. Louis</b>		c. LENGTH OF STAY (in this place) <b>15 days</b>		c. CITY OR TOWN <b>St. Louis</b>		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 <b>No. Pac. Hospital</b>				STREET ADDRESS (If rural, give location) <b>2120 So. Grand Blvd.</b>			
3. NAME OF DECEASED (Type or Print) <b>John</b>		a. (First)		b. (Middle) <b>Claude Darwin</b>		c. (Last)	
4. DATE OF DEATH (Month) (Day) (Year) <b>3-23-57</b>		5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	
8. DATE OF BIRTH <b>Jan. 10, 1897</b>		9. AGE (In years last birthday) <b>60</b>		IF UNDER 1 YEAR Months Days		IF UNDER 11 MRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supt. of Transportat.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mo. Pac. R.R.</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>BRYON TEXAS</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>J.C. DARWIN</b>		13b. MOTHER'S MAIDEN NAME <b>FANNIE WILSON</b>		14. NAME OF HUSBAND OR WIFE <b>MARTHA HODNETT</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. (If yes, give war or date of service) <b>NONE</b>		17. INFORMANT'S SIGNATURE OR NAME <b>MRS. NELSON</b>		ADDRESS <b>2120 S GRAND</b>	
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) <b>Pulmonary Emphysema</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>  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. <b>Chronic Bronchitis</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <b>5020</b>				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 <b>March 4, 1957</b> , to <b>March 22, 1957</b> , that I last saw the deceased alive on <b>March 22, 1957</b> and that death occurred at <b>5:25 a.m.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Clarence J. Sullivan, M.D.</b>				23b. ADDRESS <b>Mo. Pac. Hospital</b>		23c. DATE SIGNED <b>3-23-57</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		24b. DATE <b>3-23-57</b>		24c. NAME OF CEMETERY OR CREMATORY <b>PALESTINE CEM.</b>		24d. LOCATION (City, town, or county) (State) <b>PALESTINE, TEXAS</b>	
DATE REC'D BY LOCAL REG. <b>MAR 23 57</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>C.R. LUTTON &amp; SONS 7233 DELMAR BLVD</b>			

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 *Arnold W. Schoene*

Licensed Embalmer No. *3864*

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.