

diseases in Part I, must be causally related. Coroner cannot certify to a death due to natural causes.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION

THE DIVISION OF HEALTH OF MISSOURI				29296
STANDARD CERTIFICATE OF DEATH				STATE FILE NUMBER
Registration District No. 318		Primary Registration District No. 1003		Registrar's No. 6648
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, give TOWNSHIP only) OR TOWN 915 N.GRAND, ST. LOUIS, MO.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN ST. LOUIS	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION V.A. HOSPITAL		Length of stay in 11 DAYS	d. STREET ADDRESS 4368A EVANS (If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First DON Middle HARRISON Last CAMERON		4. DATE OF DEATH Month 7 Day 12 Year 57		
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-26-13	9. AGE (In years last birthday) 44 IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) ANNISTON, ALABAMA	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME LEE CAMERON		14. MOTHER'S MAIDEN NAME MILLIE HOWARD		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-2		16. SOCIAL SECURITY NO. 488 28 5892	17. INFORMANT Address VA HOSP. RECORDS., 915 N.GRAND, ST. LOUIS, MO.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE SCLEROSIS (CLINICAL HISTORY) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) 345x				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a. m. p. m.				
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. Attended the deceased from 7-1-57 to 7-12-57 and last saw her him alive on 7-12-57 Death occurred at 7:40 A. _____ m on the date stated above; and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE (Deputy or title) JACK M. BURNETT M.D.			22b. ADDRESS VAH, 915 N.GRAND, ST. LOUIS, MO.	22c. DATE SIGNED 7-12-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 7/17/57	23c. NAME OF CEMETERY OR CREMATORY National Cemetery	23d. LOCATION (City, town, or county) (State) Jefferson Barracks, Mo.	
24. FUNERAL DIRECTOR Charles J. Gates ADDRESS 4107 Finney		25. DATE RECD. BY LOCAL REG. JUL 16 '57	26. REGISTRAR'S SIGNATURE <i>Carl Smith M.D.</i>	

(Licensed Embalmer's Statement on Reverse Side)

THIS IS

TO CERTIFY

TO THE DEPARTMENT OF HEALTH

OF THE

STATE OF TEXAS

IN THE

RE-STATE

OF TEXAS

DEPARTMENT

OF HEALTH

AM

RE-STATE

CERTIFICATE

NO. 1

AND

STATE OF TEXAS

DEPARTMENT

OF HEALTH

STATE OF TEXAS

STATE OF TEXAS DEPARTMENT OF HEALTH

STATE OF TEXAS

STATE OF TEXAS

STATE OF TEXAS

STATE OF TEXAS

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was

by me, or by Student Embalmer No.

working under my personal supervision..

Student
Signature of Student Embalmer

Signed *Edward G. Flynn*

Licensed Embalmer No. 44

STATE OF TEXAS

STATE OF TEXAS

STATE OF TEXAS

STATE OF TEXAS

P. O. Address 4107. Fifth

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.

(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.