

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42273

State File No.

FILED DEC 9 - 1957

10822

BIRTH NO. _____		REG. DIST. NO. 318	PRIMARY REG. DIST. NO. 1003	Registrar's No. 10822
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis		
b. CITY OR TOWN St. Louis		c. CITY OR TOWN Affton	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 En Route to City Hospital		e. STREET ADDRESS (If rural, give location) 27 9290 Fayette Ave		
3. NAME OF DECEASED (Type or Print) a. (First) EARL		b. (Middle) MONTGOMERY	c. (Last) LONGWORTH	
4. DATE OF DEATH (Month) (Day) (Year) 11-11-1957		5. SEX <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		
6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 6-27-1898
9. AGE (In years last birthday) 59		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		11. BIRTHPLACE (City and State or Foreign Country) Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Cornelius P. Longworth		
13b. MOTHER'S MAIDEN NAME Martha Harbison		14. NAME OF HUSBAND OR WIFE Marie Longworth		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 493-09-2815		17. INFORMANT'S SIGNATURE OR NAME Marie Longworth ADDRESS 9290 Fayette Ave
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, arteria, etc. It means the disease, injury, or complication which caused death.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Dilatation of Heart		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. 434.3		
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) 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 1956 , 19___, to 11-9-57 , 19___, that I last saw the deceased alive on 11-9-57 , 19___, and that death occurred at 4:50 P m. , from the causes and on the date stated above.				
23a. SIGNATURE <i>[Signature]</i>		23b. ADDRESS 4930 Lindell Blvd.		23c. DATE SIGNED 11-12-57
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 11-14-1957		24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park
		24d. LOCATION (City, town, or county) (State) 10160 Gravois Road Mo		
DATE REC'D BY LOCAL REG. NOV 13 1957		REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR'S SIGNATURE Biogenhew-Bros ADDRESS 6409 Gravois Ave

Dr. Smith 3624 S. Broadway
FR 2-7017
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 *Van M. Simon*

Licensed Embalmer No. *1343*

P. O. Address *St. Louis, Mo.*

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.