

Dept. Health,  
Welfare,  
& Public  
Health Service

FILED JAN 13 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

45799

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003

Registrar's No. 12713

V. S. 300  
Rev. 1-57

securing the medical certification in the specific manner required by 193.140 MoRS 1949.  
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.  
All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO.</b> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO.</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>ST LOUIS</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>25 ST. LOUIS CITY HOSP. #1.</b>		Length of stay in lb		STREET ADDRESS <b>18 3216 HICKORY</b>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle Last <b>FARMER</b>				4. DATE OF DEATH Month <b>DEC.</b> Day <b>29</b> Year <b>1957</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-16-1928</b>		9. AGE (In years last birthday) <b>29</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>KREY PACKING CO.</b>		11. BIRTHPLACE (City and state or country) <b>ST LOUIS MO</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>DANIEL FARMER</b>		13b. MOTHER'S MAIDEN NAME <b>VIRGINIA TURNER</b>		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) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>VIRGINIA FARMER</b> Address <b>3216 Hickory</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Squamous Carcinoma of Larynx</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b)		DUE TO (c) <b>161x</b>			
- 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 type="checkbox"/> NO <input checked="" 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 <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. I attended the deceased from <b>7/29/57</b> to <b>12/29/57</b> and last saw her/him alive on <b>12/29/57</b> Death occurred at <b>6:50 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <b>Leo J. Mulligan, M.D.</b>			22b. ADDRESS <b>1515 LAFAYETTE AVE.</b>		22c. DATE SIGNED <b>12/29/57</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county)		(State)	
<b>REMOVAL</b>	<b>1-4-58</b>	<b>FATHER DICKSON</b>		<b>ST LOUIS, CO.</b>		<b>MO.</b>	
24. FUNERAL DIRECTOR <b>Bennie Lou</b> ADDRESS <b>3103 Washington</b>			25. DATE RECD. BY LOCAL REG. <b>JAN 2 '58</b>		26. REGISTRAR'S SIGNATURE <b>Carl Smith</b>		

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 *W. Claude Gordon* .....

Licensed Embalmer No. *3489* .....

P. O. Address *4575 Aldine* .....

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.