

Health, Welfare & Public Service  
 300  
 1-56  
 All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

58-011541  
 STATE FILE NUMBER

FILED APR 9 1958

318

1003

Registrar's No. 3722

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY _____					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis MO</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>			
c. FULL NAME OF HOSPITAL OR INSTITUTION <u>01 145<sup>th</sup> Franklin Av.</u>			Length of stay in lb _____		d. STREET ADDRESS <u>211 19<sup>th</sup> Street</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>RICHARD</u> First <u>Richard</u> Middle <u>DINES</u> Last <u>DINES</u>				4. DATE OF DEATH Month <u>2</u> Day <u>3</u> Year <u>1958</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH _____		9. AGE <u>24</u> years (at birthday) 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>Teacher</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (City, and state or country) <u>St. Louis, Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>None</u>				14. MOTHER'S MAIDEN NAME <u>None</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, and of what rank) (If yes, give date or dates of service) <u>None</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>T. E. Kelly, 1300 Clark</u> Address _____				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arterio Sclerotic</u> DUE TO (c) <u>Heart Disease</u>							INTERVAL BETWEEN ONSET AND DEATH _____		
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.) <u>420.0</u>						
20c. TIME OF INJURY Hour _____ 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. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>James M. Kelly</u> (Degree or title) <u>Deputy</u>				22b. ADDRESS <u>1300 Clark</u>		22c. DATE SIGNED <u>2-17-58</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>43058</u>		23b. DATE <u>4-30-58</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Anatomical Board</u>		23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>			
24. FUNERAL DIRECTOR <u>Rowland-Aker</u> ADDRESS <u>4404 Manchester</u>				25. DATE RECD. BY LOCAL REG. <u>APR 3 '58</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith</u>			

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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**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.....

Licensed Embalmer No.....

P. O. Address.....

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