

FILED FEB 26 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 6085
Registrar's No. 1488

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY OR TOWN St Louis	c. LENGTH OF STAY (in this place) 4 wks	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St Johns U		d. STREET ADDRESS (If rural, give location) 2908 Hebert	

3. NAME OF DECEASED (Type or Print) CHARLES D Curtis			4. DATE OF DEATH (Month) (Day) (Year) 2-12-1949			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH 5-27-1887	9. AGE (in years last birthday) 61	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) Weigher		10b. KIND OF BUSINESS OR INDUSTRY Fish Company	11. BIRTHPLACE (State or foreign country) St Louis O		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME Charles D Curtis	13b. MOTHER'S MAIDEN NAME Jennie Musiek	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WWI	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Prudence Mason 2908 Hebert St

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.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of the esophagus.		INTERVAL BETWEEN ONSET AND DEATH 4 MONTHS
	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. H6 150X		

19a. DATE OF OPERATION 2/1/49	19b. MAJOR FINDINGS OF OPERATION Confirmed above	20. AUTOPSY? YES <input 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 1/3/49, 19, to 2/12, 1949, that I last saw the deceased alive on 2/11, 1949, and that death occurred at 7:30 P m., from the causes and on the date stated above.

23a. SIGNATURE James L Mudd M.D.	(Degree or title) U	23b. ADDRESS 634 Grand Blvd St Louis Mo	23c. DATE SIGNED 2/14/49
24a. BURIAL, CREMATION/REMOVAL (Specify) Burial	24b. DATE 2-15-49	24c. NAME OF CEMETERY OR CREMATORY Bellefontaine St Louis	24d. LOCATION (City, town, or county) (State) Mo

DATE REC'D BY LOCAL REG. FEB 16 1949	REGISTRAR'S SIGNATURE J. B. Lawton	FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary, Svc 4104 Manchester	ADDRESS
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

40

1488

Handwritten signature

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.

Signed *Howard E. Rowland*

Signed
Student Embalmer

Licensed Embalmer No. 3114

P. O. Address St Louis 10 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 this body is not embalmed, fact should be so stated above.