

FILED MAY 5 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 14063  
Registrar's No. 3590

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 3590	
1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Louis Mo.</u> c. LENGTH OF STAY (in this place) _____ d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>City Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____ c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St Louis</u> d. STREET ADDRESS (If rural, give location) <u>5800 Arsenal St</u>			
3. NAME OF DECEASED (Type or Print) <u>John F. Platt</u> a. (First) _____ b. (Middle) _____ c. (Last) _____			4. DATE OF DEATH (Month) (Day) (Year) <u># 7 29 49</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>		8. DATE OF BIRTH <u>6/21/1877</u>	
9. AGE (In years last birthday) <u>71</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 12 MOS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardner</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Unknown</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		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) <u>Unknown</u>			16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>James A. Ryan 4919 Lisette</u>		
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Subdural hemorrhage</u> ANTECEDENT CAUSES <u>Pulmonary Congestion</u> DUE TO (b) <u>when he fell to the floor at City Infirmary Hosp.</u> DUE TO (c) <u>Division of an April 12th 1949 about 2:45 pm</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					INTERVAL BETWEEN ONSET AND DEATH _____
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION <u>None</u>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>Accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>City Infirmary</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>St Louis Mo</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) <u>Apr 12 49 2:45 p.m.</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>fall</u>			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>4:30 P.M.</u> , from the causes and on the date stated above.							
22a. SIGNATURE (Degree or title) <u>Cathel E Taylor Coronel</u>				22b. ADDRESS <u>1300 Clark</u>		22c. DATE SIGNED <u>4-21-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>4/22/1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park</u>		24d. LOCATION (City, town, or county) (State) <u>St Louis Mo</u>	
DATE REC'D BY LOCAL REG. <u>APR 21 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Lister</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Aug Marcel 4117 St Louis Ave</u>			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.

Signed \_\_\_\_\_

*Robert M Murray*

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. *3749*

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 this body is not embalmed, fact should be so stated above.