

FILED MAY 18 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 17628  
4150

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No.		
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN				a. STATE				
c. LENGTH OF STAY (in this place)				b. COUNTY				
d. FULL NAME OF HOSPITAL OR INSTITUTION				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN				
e. STREET ADDRESS (If rural, give location)				d. FULL NAME OF HOSPITAL OR INSTITUTION				
3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH			5. SEX		
a. (First)			b. (Middle)			c. (Last)		
6. COLOR OR RACE			7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)			8. DATE OF BIRTH		
9. AGE (In years last birthday)			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY?		
13a. FATHER'S NAME			13b. MOTHER'S MAIDEN NAME			14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT'S SIGNATURE OR NAME ADDRESS		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)			MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)			Cerebral Thrombosis				1 1/2 Mos.	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.			with Decompensation Arteriosclerotic Heart Disease					
II. OTHER SIGNIFICANT CONDITIONS			None					
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY?		
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 3-22, 1949, to 5-5, 1949, that I last saw the deceased alive on 5-5, 1949, and that death occurred at 9:15 P.M., from the causes and on the date stated above.								
23a. SIGNATURE (Degree or title)			23b. ADDRESS			23c. DATE SIGNED		
24a. BURIAL, CREMATION, REMOVAL (Specify)			24b. DATE			24c. NAME OF CEMETERY OR CREMATORY		
24d. LOCATION (City, town, or county) (State)			24e. NAME OF CEMETERY OR CREMATORY			24f. LOCATION (City, town, or county) (State)		
DATE REC'D BY LOCAL REG.			REGISTRAR'S SIGNATURE			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		

(Licensed Embalmer's Statement on Reverse Side)

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 .....  
Student Embalmer

Signed F. G. Green.....

Licensed Embalmer No. 2963.....

P. O. Address 4214 Delmar.....

**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.