

FILED JUL 30 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 25133
6232

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) a. STATE b. COUNTY				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN				
d. FULL NAME OF HOSPITAL OR INSTITUTION				STREET ADDRESS (If rural, give location)				
3. NAME OF DECEASED (Type or Print)			a. (First)		b. (Middle)		c. (Last)	
4. DATE OF DEATH		(Month)		(Day)		(Year)		
5. SEX		6. COLOR OR RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH		
9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HOURS		IF UNDER 24 MIN.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		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								
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)								
ANTECEDENT CAUSES								
II. OTHER SIGNIFICANT CONDITIONS								
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						
20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" 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) (Min)		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 _____/_____, 19____ to _____/_____, 19____, that I last saw the deceased alive on _____/_____, 19____, and that death occurred at _____ a.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)		
DATE REC'D BY LOCAL 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.

Signed.....

F. G. Green

Signed.....

Student Embalmer

Licensed Embalmer No.

2963

P. O. Address.....

4214 Delaware

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.