

FILED MAR 23 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10330

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **2231**

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

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 OR TOWN ST. LOUIS)		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) ST. LOUIS		
d. FULL NAME OF HOSPITAL OR INSTITUTION 415 PINE ST		d. STREET ADDRESS (If rural, give location) 13-5425 S. 37th ST.				
3. NAME OF DECEASED (Type or Print) a. (First) CALVIN		b. (Middle) M.		c. (Last) DANIELS		
4. DATE OF DEATH (Month) (Day) (Year) MARCH 7 - 1950		5. SEX M.		6. COLOR OR RACE W.		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH JULY-12-1899		9. AGE (In years last birthday) 50 YRS		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ARKANSAS/APLIM		
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME WILLIAM DANIELS		13b. MOTHER'S MAIDEN NAME ALLIE M^e LAREN		
14. NAME OF HUSBAND OR WIFE ADA M. DANIELS		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Wk 2		16. SOCIAL SECURITY NO.		
17. INFORMANT'S SIGNATURE OR NAME Mrs Ada M. Daniels		17. ADDRESS 5424 S. 37th 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, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		ANTECEDENT CAUSES				
DUE TO (b)		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				
DUE TO (c)		Chronic Endocarditis				
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.				
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" 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) 421 D		
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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 12:30 P. m., from the causes and on the date stated above.						
23a. SIGNATURE (Degree or title) Patric E. Taylor, Cor		23b. ADDRESS 1300 Clark		23c. DATE SIGNED 3-8-50		
24a. BURIAL CREMATION (Specify) BURIAL		24b. DATE MARCH 11 - 1950		24c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK Cem.		
24d. LOCATION (City, town, or county) (State) St. Louis Mo.		DATE REC'D BY LOCAL REG. MAR 8 1950		REGISTRAR'S SIGNATURE J. B. Foster		
25. FUNERAL DIRECTOR'S SIGNATURE E. J. Schmur		ADDRESS 3125 Lafayette Av				

MAR 27 1950

male

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 *John B. Hollman*
Licensed Embalmer No. *4014*

P. O. Address *125 Lafayette*

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.