

FILED MAR 23 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 10477

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2264

3410

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

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY   |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |  |
| b. CITY (If outside corporate limits, write RURAL and give township)                 |  | b. COUNTY   |  |
| c. LENGTH OF STAY (In this place)  |  | c. CITY (If outside corporate limits, write RURAL and give township)                  |  |
| d. FULL NAME OF (If not in hospital or institution, give street address or location) |  | d. STREET ADDRESS (If rural, give location)   |  |

|                                     |                                  |  |                              |
|-------------------------------------|----------------------------------|--|------------------------------|
| 3. NAME OF DECEASED (Type or Print) |                                  | 4. DATE OF DEATH (Month) (Day) (Year)                  |                              |
| a. (First)                          |                                  | a. (Month)   |                              |
| b. (Middle)                         |                                  | b. (Day)   |                              |
| c. (Last)                           |                                  | c. (Year)  |                              |
| 5. SEX                              | 6. COLOR OF RACE                 | 7. MARRIED—NEVER MARRIED, WIDOWED, DIVORCED, SEPARATED | 8. DATE OF BIRTH             |
| 9. AGE (In years) (Not birthday)    | 10. 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) (If yes, give year of date of service) | 16. SOCIAL SECURITY NO.   | 17. INFORMANT'S SIGNATURE OR NAME |
|  |                           | ADDRESS                           |

|   |  |   |  |                                  |  |
|---|--|---|--|----------------------------------|--|
| 18. CAUSE OF DEATH<br>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)  |  | II. OTHER SIGNIFICANT CONDITIONS  |  |                                  |  |
| *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death. |  | 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)                                  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) | 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 \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at \_\_\_\_\_ 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 RECD BY REG. MAR 9 1950 | REGISTRAR'S SIGNATURE | 25. FUNERAL DIRECTOR'S SIGNATURE       |
|                              | J. B. Basater         | Rowland Mortuary Services Inc.         |
|                              |                       | 4104 Manchester Ave. St. Louis 10, Mo. |

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  
at College of Mortuary Science, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student .....  
Student Embalmer

Signed Ralph W Henson

Licensed Embalmer No. 3791

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.