

FILED MAR 7 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **6125**
REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **1872**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 1872	
1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Missouri b. COUNTY St. Louis			
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (In this place) 6 weeks		c. CITY (If outside corporate limits, write RURAL and give township) St. Charles Mo		0923	
d. FULL NAME OF HOSPITAL OR INSTITUTION Deaconess Hospital				d. STREET ADDRESS (If rural, give location) 503 Tompkins			
3. NAME OF DECEASED (Type or Print)		a. (First) William		b. (Middle) Albert		c. (Last) Givens	
4. DATE OF DEATH		(Month)		(Day)		(Year)	
Feb 22 1951							
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH December 19 1896		9. AGE (In years last birthday) Months Days Hours Min. 54	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Confectionary		11. BIRTHPLACE (State or foreign country) Parkerburgs West Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME Oscar Givens		13b. MOTHER'S MAIDEN NAME Clara Thompson		14. NAME OF HUSBAND OR WIFE Martha Givens			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World War # 1		16. SOCIAL SECURITY NO. 328-09-1689		17. INFORMANT'S SIGNATURE OR NAME Martha Givens 503 Tompkins			
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) CHR. NEPHRITIS HYPERTENSION DUE TO (a)				INTERVAL BETWEEN ONSET AND DEATH 2 Mo's. 1 yr +	
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? 672X			
22. I hereby certify that I attended the deceased from 1-11 , 19 51 , to 2-22 , 19 51 , that I last saw the deceased alive on 2-22 , 19 51 , and that death occurred at 1:35 a.m., from the causes and on the date stated above.							
23a. SIGNATURE Robert E. Koch				23b. ADDRESS 35N. CENTRAL		23c. DATE SIGNED 2-24-51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Feb 26 1951		24c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery		24d. LOCATION (City, town, or county) (State) St. Charles Mo.	
DATE REC'D BY LOCAL REG. FEB 26 1951		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR'S SIGNATURE Hackmann - Rowe		ADDRESS St. Charles Mo.	

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

1967 81 706

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 _____

Arthur C. Paul

Licensed Embalmer No. _____

3151

P. O. Address _____

Michael M.

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.