

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3414

FILED JAN 26 1952

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **0200**

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 Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) St Louis mo		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (In this place) 2 days		2229	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL		2b. STREET ADDRESS (If rural, give location) 1303 Armstrong	
3. NAME OF DECEASED (Type or Print) a. (First) Wilton b. (Middle) c. (Last) Trice		4. DATE OF DEATH (Month) (Day) (Year) 1 - 7 - 52	
5. SEX M	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH June 30, 1913
9. AGE (In years last birthday) 38		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Finisher		10b. KIND OF BUSINESS OR INDUSTRY Scullins Steel	11. BIRTHPLACE (State or foreign country) O'Bine County, Tenn.
12. CITIZEN OF WHAT COUNTRY? U.S.A		13a. FATHER'S NAME Lum Trice	
13b. MOTHER'S MAIDEN NAME Lillian Frye		14. NAME OF HUSBAND OR WIFE Caldon Trice	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 415-14-7949	
17. INFORMANT'S SIGNATURE OR NAME Caldon Trice		ADDRESS 1303 Armstrong	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CEREBRAL VASCULAR ACCIDENT ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) HYPERTENSIVE CARDIOVASCULAR DISEASE SEV. YEARS DUE TO (c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH 12 HOURS	
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) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? HK 3X	
22. I hereby certify that I attended the deceased from 1-6 , 19 52 , to 1-7 , 19 52 , that I last saw the deceased alive on 1-7 , 19 52 , and that death occurred at 12:45 A m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Earl Smith M.D.		23b. ADDRESS BARNES HOSPITAL	
23c. DATE SIGNED 1/7/52			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 1-11-52	24c. NAME OF CEMETERY OR CREMATORY Oakgrove Cemetery	24d. LOCATION (City, town, or county) (State) Henderson, Tenn.
DATE REC'D BY LOCAL REG. JAN 8 1952		REGISTRAR'S SIGNATURE Earl Smith M.D.	
52. FUNERAL DIRECTOR'S SIGNATURE E. B. Roonee		ADDRESS 1221 N. Grand	

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 Lawrence Cronin

Licensed Embalmer No. 4755

P. O. Address 1221 N. Grand

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.