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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **6191**
Registrar's No. **1492**

FILED MAR 5 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
c. b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis 2239	
c. LENGTH OF STAY (in this place) 7 days		d. STREET ADDRESS (If rural, give location) 23 2720 Eads, A.O.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Missouri Pacific Hosp.			

3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) Walter c. (Last) Alexander			4. DATE OF DEATH (Month) (Day) (Year) Feb 14, 1952		
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 24, 1889	9. AGE (In years last birthday) 62	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tram, trolleyman operator		10b. KIND OF BUSINESS OR INDUSTRY Railroad	11. BIRTHPLACE (State or foreign country) Ill.	12. CITIZEN OF WHAT COUNTRY? U.S.	

13a. FATHER'S NAME LOUIS ALEXANDER		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE ADA ALEXANDER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME VERA ALEXANDER ADDRESS 2720 EADS	

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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage ANTECEDENT CAUSES (b) Cerebral arteriosclerosis DUE TO (c) Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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 1 week	
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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) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21h. HOW DID INJURY OCCUR? 33 FX	

22. I hereby certify that I attended the deceased from **Feb 7, 1952** to **Feb 14, 1952**, that I last saw the deceased alive on **Feb 14, 1952**, and that death occurred at **3:50 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Clarence J. Sullivan, M.D.		23b. ADDRESS		23c. DATE SIGNED	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 2-16-52		24c. NAME OF CEMETERY OR CREMATORY St. Matthews		24d. LOCATION (City, town, or county) (State) St. Louis Mo.	
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DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE FEB 18 1952		REGISTRAR'S SIGNATURE Carl Smith MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS McLAUGHLIN FUNERAL HOME, INC. 2301 W. BAYETTE	
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WRITE PLAINLY—USING UNFADEING BLACK INK—MAKE A PERMANENT RECORD

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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 _____

H. J. Ferris

Licensed Embalmer No. 3384
P. O. Address 2301 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.