

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21945

State File No.

FILED JUN 27 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5102**

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WRITE PLAINLY—USING UNFADING 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 Mo. 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		2109	
d. FULL NAME OF HOSPITAL OR INSTITUTION DOA City Hospital		d. STREET ADDRESS (If rural, give location) 4475 Labadie avenue	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) broom maker		10b. KIND OF BUSINESS OR INDUSTRY Broom Mfg.	
11. BIRTHPLACE (City and State or Foreign Country) Watson, Ill.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME unknown		13b. MOTHER'S MAIDEN NAME unknown	
14. NAME OF HUSBAND OR WIFE unknown			
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. unknown	
17. INFORMANT'S SIGNATURE OR NAME Iddy I James,		ADDRESS 4475 Labadie ave.	
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) ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Ruptured Aortic Aneurysm DUE TO (c) 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)			
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? 451X			
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 8:20 A m., from the causes and on the date stated above.			
22a. SIGNATURE Patrick E Taylor, Coroner		22b. ADDRESS 1300 Clark	
22c. DATE SIGNED 6.4.52			
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 6-4-52	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State) Mattoon, Ill.	
24. DATE REC'D BY LOCAL REG. JUN 4 1952		24. REGISTRAR'S SIGNATURE J. Carl Smith, MD	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS Mitchell, Mattoon, Ill.	

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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 Ben Koffman

Licensed Embalmer No. 4366

P. O. Address 1400 1st St

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.