

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED JAN 10 1953

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

Registrar's No. 11589

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY	
b. CITY OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2219	
d. FULL NAME OF HOSPITAL OR INSTITUTION SE MARY INFIRMARY		d. STREET ADDRESS (If rural, give location) 2837 ^a DICKSON ST.	
3. NAME OF DECEASED (Type or Print) a. (First) RANSOM		b. (Middle) BATTLE	
c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) 12 14 52	
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH Feb. 17 1887
9. AGE (In years last birthday) 65		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PORTER	11. BIRTHPLACE (City and State or Foreign Country) Ala.
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME PHILLIP BATTLE	
13b. MOTHER'S MAIDEN NAME UNKNOWN		14. NAME OF HUSBAND OR WIFE LOTTIE BATTLE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Lottie Battle		ADDRESS 2837 ^a Dickson	
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) Respiratory Obstruction ANTECEDENT CAUSES (b) Carcinoma of Larynx Morbidity 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.	
19a. DATE OF OPERATION 11-29-52		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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 161X			
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 11 A.M., from the causes and on the date stated above.			
23a. SIGNATURE J. L. Griffin, M.D.		23b. ADDRESS 2601 N. W. Lottier St.	
23c. DATE SIGNED 12-14-52			
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE 12-18-53	
24c. NAME OF CEMETERY OR CREMATORY WASHINGTON PARK		24d. LOCATION (City, town, or county) (State) ST. LOUIS CTY MO	
DATE REC'D BY LOCAL REG. DEC 17 1952		REGISTRAR'S SIGNATURE J. Carl Smith	
25. FUNERAL DIRECTOR'S SIGNATURE W. A. F. WALTON		ADDRESS 2707 STODDARD ST.	

(Licensed Embalmer's Statement on Reverse Side)

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

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 S. Hilliard

Licensed Embalmer No. 4291

P. O. Address 4524 Aldine

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.