

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **45154**
Registrar's No. **11839**

FILED JAN 26 1953
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)	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		a. STATE MISSOURI b. COUNTY ST. LOUIS	
c. LENGTH OF STAY (In this place) 1 DAY		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN AFFTON 4830	
d. FULL NAME OF HOSPITAL OR INSTITUTION INCARNATE WARD HOSP.		d. STREET ADDRESS (If rural, give location) 10,000 GRAVOIS 1	

3. NAME OF DECEASED (Type or Print)	a. (First) GEORGE	b. (Middle) W	c. (Last) WHITE	4. DATE OF DEATH (Month) (Day) (Year)
				DEC 22 1952

5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JAN 13 1897	9. AGE (In years last birthday) 55	10. UNDER 1 YEAR	11. UNDER 1 HR.
					Month	Days

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED	10b. KIND OF BUSINESS OR INDUSTRY RETIRED	11. BIRTHPLACE (City and State or Foreign Country) WISCONSIN 1	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME CHARLES WHITE	13b. MOTHER'S MAIDEN NAME ROSE CARTER	14. NAME OF HUSBAND OR WIFE LENA WHITE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. (If yes, give year or dates of service) NONE	17. INFORMANT'S SIGNATURE OR NAME LENA WHITE	ADDRESS 10,000 GRAVOIS.
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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		INTERVAL BETWEEN ONSET AND DEATH 5 day 23 yr
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Left Pneumonia, Bilateral		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Paro plegia DUE TO (b) 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 type="checkbox"/> NO <input checked="" type="checkbox"/>
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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? 490X

22. I hereby certify that I attended the deceased from **12-20**, 19**52**, to **12-23**, 19**52**, that I last saw the deceased alive on **12-22**, 19**52**, and that death occurred at **11:20** a.m., from the causes and on the date stated above.

23a. SIGNATURE Laura J. Stephens	(Degree or title) M.O.	23b. ADDRESS 4979 Chipmunk Ave	23c. DATE SIGNED 12-26-52
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24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	24b. DATE DEC 26 1952	24c. NAME OF CEMETERY OR CREMATORY RESURRECTION CEM	24d. LOCATION (City, town, or county) (State) ST. LOUIS. MO.
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DATE REC'D BY LOCAL REG. 12-24-52	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE McThomas Kutis	ADDRESS 2906 Gravois
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

No. 300
10-48

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

Samuel C. Dill

Licensed Embalmer No.

4347 91

P. O. Address

2906 Travis

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.