

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37704
9767

State File No. _____
Registrar's No. _____

FILED OCT 23 1953
BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

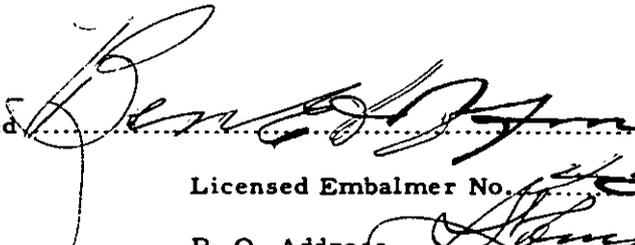
1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	d. Is residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION D.O.A. City Hospital		STREET ADDRESS (If rural, give location) 22 1504 Market street 2229	
3. NAME OF DECEASED (Type or Print) a. (First) JAMES b. (Middle) EDWARD c. (Last) WHITWORTH		4. DATE OF DEATH (Month) (Day) (Year) 10-8-53	
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) divorced	8. DATE OF BIRTH 11-2-1912
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY general labor	9. AGE (In years last birthday) 40 11. BIRTHPLACE (City and State or Foreign Country) Missouri 12. CITIZEN OF WHAT COUNTRY? USA
13a. FATHER'S NAME William Whitworth		13b. MOTHER'S MAIDEN NAME Bertha Farley	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 ADDRESS Chas. Whitworth, Pacific, Mo.
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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchial Asthma Pulmonary Tuberculosis 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 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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 002X	
22. I hereby certify that I attended the deceased from 19 4051, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Patrick C. Taylor, M.D.		23b. ADDRESS 1300 Clark	23c. DATE SIGNED 10.13.53
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 10-10-53	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State) Pacific, Mo.
DATE REC'D BY LOCAL REG. OCT 13 1953	REGISTRAR'S SIGNATURE J. Carl Smith, M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Thiebes F.H., Pacific, Mo.	

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.....
Signature of Student Embalmer

Signed .....
Licensed Embalmer No. .....
P. O. Address .....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.