

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

3787

State File No. ....

FILED JAN 21 1954

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 366 PRIMARY REG. DIST. NO. 6248 Registrar's No. 6

1. PLACE OF DEATH a. COUNTY <u>Washington Co.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Washington</u>	
b. CITY (If outside corporate limits, give RURAL and give township) OR TOWN <u>Rural Richwoods</u>		c. CITY OR TOWN <u>Richwoods</u>	
c. LENGTH OF STAY (in this place)		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>At Home</u>		e. STREET ADDRESS (If rural, give location) <u>none - Richwoods mo</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>David</u> b. (Middle) <u>Harold</u> c. (Last) <u>Courtway</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 10 1954</u>		
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Singles</u>	
8. DATE OF BIRTH <u>June 11 1951</u>		9. AGE (In years last birthday) <u>2</u>		IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> IF UNDER 4 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Washington, County, Mo.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					

13a. FATHER'S NAME <u>Raymond LONZO Courtway</u>		13b. MOTHER'S MAIDEN NAME <u>Corine A Courtway</u>		14. NAME OF HUSBAND OR WIFE <u>✓</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mr. C. L. Turner</u> ADDRESS <u>St. Clair Mo</u>	

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.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cancer of Brain</u>		INTERVAL BETWEEN ONSET AND DEATH <u>18 months</u>	
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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. <u>193X</u>			

19a. DATE OF OPERATION <u>1953 - St. Louis</u>		19b. MAJOR FINDINGS OF OPERATION <u>Brain child mis. Hosp. Cancer of Brain</u>		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"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan -, 1952, to Jan 10, 1954, that I last saw the deceased alive on Dec -, 1953, and that death occurred at 6 P. m., from the causes and on the date stated above.

23a. SIGNATURE <u>D. W. E. Kitchell M.D.</u> (Degree or title)		23b. ADDRESS <u>St. Clair - Mo</u>		23c. DATE SIGNED <u>1/10/54</u>	
--	--	------------------------------------	--	---------------------------------	--

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Jan 11 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Drybrake Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Washington County, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>1-14-54</u>		REGISTRAR'S SIGNATURE <u>Hybruk wudall</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Sherwood W Kitchell</u>		ADDRESS <u>St. Clair Mo</u>	

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

1100

WASH. COUNTY HEALTH DEPT.

JAN 19 1954

RECEIVED

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 *Shirley E. Kitchel*

Licensed Embalmer No. \_\_\_\_\_

P. O. Address \_\_\_\_\_

*Not Embalmed*

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.