

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED MAR-15 1954

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Faith Hos, Taylor &amp; Maffitt</b>		e. STREET ADDRESS (If rural, give location) <b>20 2505 Dodier St</b>		220/0			
3. NAME OF DECEASED (Type or Print) a. (First) <b>CORA</b> b. (Middle) c. (Last) <b>WHITE</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>3/4/54</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Mar. 14/1893</b>	9. AGE (In years last birthday) <b>60</b>	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>Boone County, Mo.,</b>			
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME <b>Mathew Barnes</b>		13b. MOTHER'S MAIDEN NAME <b>Sarah Alice Pugh</b>			
14. NAME OF HUSBAND OR WIFE <b>Lawrence White</b>		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. <b>Unknown</b>			
17. INFORMANT'S SIGNATURE OR NAME <b>Law. White</b>		ADDRESS <b>2505 Dodier St</b>					
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, asthenia, etc. It means the disease, injury, or complication which caused death.		19. MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Dissecting Aneurysm of the Aorta</b> 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. <b>Cerebral thrombosis</b>				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		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) <b>St. Louis Mo.</b>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>451X</b>			
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 <b>10:30 AM.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Lawrence W. Lawton MS</b>		23b. ADDRESS <b>2801 N. Taylor</b>		23c. DATE SIGNED <b>3/5/54</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>3/6/54</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Memorial Pk. Cem</b>			
24d. LOCATION (City, town, or county) (State) <b>Columbia, Mo.,</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Leidner Und. Co. 2223 St. Louis Av.</b>					

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

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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.....  
Signature of Student Embalmer

Signed *H. W. Wilkins*.....

Licensed Embalmer No. *35*.....

P. O. Address *M. Lou*.....

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.