

STANDARD CERTIFICATE OF DEATH

FILED JUL 1 - 1954

State File No.

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 4798

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 OR TOWN) St. Louis		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN Jennings	
d. FULL NAME OF HOSPITAL OR INSTITUTION Depaul Hospital		e. STREET ADDRESS (If rural, give location) 7030 Minnie Ave			
3. NAME OF DECEASED (Type or Print) Louis		a. (First)		b. (Middle) A.	
		c. (Last) Globe		4. DATE OF DEATH (Month) (Day) (Year) May 29 1954	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) never married	8. DATE OF BIRTH Apr. 27 1875		9. AGE (In years) (In years) (Month) (Day) (Year) 79
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo.	
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME Patrick Globe		13b. MOTHER'S MAIDEN NAME Unknown	
14. NAME OF HUSBAND OR WIFE		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 Donald Behan		ADDRESS 7030 Minnie Ave			

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) Chronic Lymphatic Leukemia		INTERVAL BETWEEN ONSET AND DEATH Unknown	
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.					
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)	
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? 2040	

22. I hereby certify that I attended the deceased from 5/14 1954 to 5/28 1954, that I last saw the deceased alive on 5/28, 1954, and that death occurred at 1:15 PM from the causes and on the date stated above.

23a. SIGNATURE Robert A. Bauer M.D.		23b. ADDRESS 3131 Goodfellow		23c. DATE SIGNED 5/29/54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 6/1/54		24c. NAME OF CEMETERY OR CREMATORY Calvary	
		24d. LOCATION (City, town, or county) (State) St. Louis Mo.			

DATE REC'D BY LOCAL REG. JUN 1 1954		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Sullivan's 2849 N. Euclid Ave	
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(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.....
Signature of Student Embalmer

Signed *Albert Mayfield*
Licensed Embalmer No. *307*
P. O. Address *St Louis*

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.