

FILED OCT 4 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

318

1003

State File No. 31604

Registrar's No. 8218

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No. 31604	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE _____ Mo. b. COUNTY _____ St. Louis			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN Richmond Hts.		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 ST. LOUIS CITY HOSPITAL				e. STREET ADDRESS (If rural, give location) 1010 Hi-Pointe			
3. NAME OF DECEASED (Type or Print) a. (First) MAURICE		b. (Middle) JOHN		c. (Last) ARCHDEACON, JR.		4. DATE OF DEATH (Month) (Day) (Year) SEPTEMBER 5, 1954	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Dec. 14, 1898	
9. AGE (In years last birthday) 55		10. KIND OF BUSINESS OR INDUSTRY Entertainment		11. BIRTHPLACE (City and State or Foreign Country) St. Louis Mo.		12. CITIZEN OF WHAT COUNTRY? _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baseball Scout		13a. FATHER'S NAME Maurice Archdeacon		13b. MOTHER'S MAIDEN NAME Mary A. Bruce		14. NAME OF HUSBAND OR WIFE Eleanor Archdeacon	
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. Unknown		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Eleanor Archdeacon 1010 Hi-Pointe			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>This does not mean the mode of dying, such as death by fire, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hypertensive Cardiovascular Disease</u> ANTECEDENT CAUSES <u>Arteriosclerosis</u> Morbidity 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 <u>Cerebral Vascular Accident</u> Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND 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) m. _____	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____ 442x					
22. I hereby certify that I attended the deceased from <u>8-10-54</u> , 19 <u>54</u> , to <u>9-5-54</u> , 19 <u>54</u> , that I last saw the deceased alive on <u>9-5-54</u> , 19 <u>54</u> , and that death occurred at <u>2:05A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Walter H. Austin M.D.</u> (Degree or title) C				23b. ADDRESS <u>1515 Lafayette Avenue</u>		23c. DATE SIGNED <u>9-6-54</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>9-8-54</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>SEP 7 1954</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Sullivan's</u>		ADDRESS <u>2849 N. Euclid Ave.</u>	

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. *3077*
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.