

FILED DEC 16 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 42852
Registrar's No. 10500

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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

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. LENGTH OF STAY (In this place) DIXIE		c. CITY OR TOWN St. Louis		d. In Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION: D. O. A. City Hospital				e. STREET ADDRESS (If rural, give location) 18 4542 Manchester Avenue 2189 0					
3. NAME OF DECEASED (Type or Print) a. (First) Michael			b. (Middle) Wayne		c. (Last) Storie		4. DATE OF DEATH (Month) (Day) (Year) Nov. 17, 1954		
5. SEX Male 0	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married 0		8. DATE OF BIRTH June 18, 1953		9. AGE (In years last birthday) 1	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri 0		12. CITIZEN OF WHAT COUNTRY? USA		
13a. FATHER'S NAME Howard W. Storie			13b. MOTHER'S MAIDEN NAME Lorraine M. Morefield		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) no		16. SOCIAL SECURITY NO. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Lorraine M. Storie, 4542 Manchester					
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) Fractured Skull; Subdural Hemorrhage; suffered when struck by car operated by one David Hughes, in front of about 6934 Squadron Ave., about 754 pm., Nov 17, 1954. II. OTHER SIGNIFICANT CONDITIONS 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 Accident 00				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT (Specify) SUICIDE HOMICIDE Accident		21b. PLACE OF INJURY (e.g., in or about home, farm, street, etc.) Street		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis Mo. E 812.4					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Nov 17 54 7:30 PM		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 25					
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 8:20 PM, from the causes and on the date stated above.									
22a. SIGNATURE (Degree or title) Cathel Taylor Carver				22b. ADDRESS 1300 Clark		22c. DATE SIGNED 11.18.54			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Nov. 20, 1954		24c. NAME OF CEMETERY OR CREMATORY Lake Charles Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis County, Mo.			
DATE REC'D BY LOCAL REG. NOV 18 1954		REGISTRAR'S SIGNATURE J. Carl Smith MOC		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Hoffmeister Colonial Mortuary, Chippewa 6464					

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 *James C. Hoffmeister*.....

Licensed Embalmer No. 387.....

P. O. Address 7814 S.P.

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.