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Reg. #6758

SL #3123

FILED SEP 29 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31371

State File No.

7761

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 Missouri b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) TOWN 915 N. Grand, St. Louis, Mo.		c. LENGTH OF STAY (In this place) 195 days		c. CITY OR TOWN St. Louis	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION VETERANS ADMINISTRATION HOSP.		STREET ADDRESS (If rural, give location) 22 1534 Market St.			
3. NAME OF DECEASED (Type or Print) a. (First) CHARLES b. (Middle) W. c. (Last) RADFORD		4. DATE OF DEATH (Month) (Day) (Year) September 5, 1955			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced	8. DATE OF BIRTH 11/3/87	9. AGE (In years last birthday) 67	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) Jacksonville, Illinois	
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME William Radford		13b. MOTHER'S MAIDEN NAME Sarah Baldwin	
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) Yes WW-1		16. SOCIAL SECURITY NO. 357-09-4242	
17. INFORMANT'S SIGNATURE OR NAME VA Hosp. Records, St. Louis, Mo.		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Cancer of Tongue with Carcinomatosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u> II. OTHER SIGNIFICANT CONDITIONS <i>Conditions contributing to the death but not related to the disease or condition causing death.</i> ANTECEDENT CAUSES <i>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</i> DUE TO (b) DUE TO (c)			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION 141X		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) VA		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 2/22 , 19 55 , to 9/5 , 1955, and that death occurred at 1:10 A.M. , from the causes and on the date stated above.					
23a. SIGNATURE Murray M. Bett		(Degree or title) M.D.		23b. ADDRESS VA Hosp., St. Louis, Mo.	
23c. DATE SIGNED 9/5/55		24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 9/5/55	
24c. NAME OF CEMETERY OR CREMATORY Camp Butler Natl Cem		24d. LOCATION (City, town, or county) (State) Springfield, Ill			
DATE REC'D BY LOCAL REG. SEP 6 1955		REGISTRAR'S SIGNATURE J. Earl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Edward Tendler	
				ADDRESS 5611 S Grand	

M. J. B. (Licensed Embalmer's Statement on Reverse Side) or

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

No. 300
10. 48

3506

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 *William J. [Signature]*

Licensed Embalmer No. *403*

P. O. Address *3525 [Address]*

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.