

FILED SEP 22 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **31809**

BIRTH NO. _____		REG. DIST. NO. 317		PRIMARY REG. DIST. NO. 544		Registrar's No. 2091			
1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis					
b. CITY (If outside corporate limits, write RURAL and give township) Kirkwood		c. LENGTH OF STAY (If this place) 30 days		c. CITY OR TOWN Rock Hill		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. Joseph's Hospital				e. STREET ADDRESS (If rural, give location) 1049 Rockman Pl.					
3. NAME OF DECEASED (Type or Print) a. (First) ROY			b. (Middle) A.		c. (Last) WHITLEY		4. DATE OF DEATH (Month) (Day) (Year) Sept. 5, 1955		
5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 5-16-1910	9. AGE (In years) (by birthday) 45	IF UNDER 1 YEAR Months 3 Days 19	IF UNDER 24 HRS. Hours Min. 		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) City Clk. Treas. & Coll.		10b. KIND OF BUSINESS OR INDUSTRY Municipality		11. BIRTHPLACE (City and State or Foreign Country) Wichita, Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13a. FATHER'S NAME William Whitley			13b. MOTHER'S MAIDEN NAME Inez Eggers		14. NAME OF HUSBAND OR WIFE Marie Bokern Whitley				
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. 494-03-3731		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Marie Whitley, above					
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, ashenia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Intestinal Obstruction ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Peritonitis DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death Adenocarcinoma Colon 153x				INTERVAL BETWEEN ONSET AND DEATH 9 days	
19a. DATE OF OPERATION 8-27-55 9-2-55		19b. MAJOR FINDINGS OF OPERATION 8-27-55 - Extensive Carcinoma 9-3-55 - Acute Intestinal Obstruction splenic flexure colon				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) (Min.)		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 8-6 , 19 55 , to 9-5 , 19 55 , that I last saw the deceased alive on 9-5-55 , 19 55 , and that death occurred at 1:00 a.m. , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) H. L. Dombroski M.D.				23b. ADDRESS 508 N. Grand Blvd. St. Louis, Mo.		23c. DATE SIGNED 9-6-1955			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 9-8-55		24c. NAME OF CEMETERY OR CREMATORY Laurel Hill Gardens		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.			
DATE REC'D BY LOCAL REG. 9-7-55		REGISTRAR'S SIGNATURE Herbert R. Dombroski M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS JAY B. SMITH, Maplewood, Mo.					

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.....
Licensed Embalmer No. 405

P. O. 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.**