

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

FILED JAN 6 1956

State File No. **41830**
11427

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 | | b. COUNTY | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN | | c. LENGTH OF STAY (in this place) township) | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION | | d. STREET ADDRESS (If rural, give location) | | | |
| 3. NAME OF DECEASED (Type or Print) | | a. (First) | | b. (Middle) | |
| c. (Last) | | 4. DATE OF DEATH | | (Month) (Day) (Year) | |
| 5. SEX | | 6. COLOR OR RACE | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) | |
| 8. DATE OF BIRTH | | 9. AGE (In years last birthday) | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | | 13a. FATHER'S NAME | |
| 13b. MOTHER'S MAIDEN NAME | | 14. NAME OF HUSBAND OR WIFE | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give way or dates of service) | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT'S SIGNATURE OR NAME | | ADDRESS | |
| 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. | | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) | | MEDICAL CERTIFICATION | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. | | 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) | | 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 _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above. | | | | | |
| 23a. SIGNATURE (Degree or title) | | 23b. ADDRESS | | 23c. DATE SIGNED | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) | | 24b. DATE | | 24c. NAME OF CEMETERY OR CREMATORY | |
| 24d. LOCATION (City, town, or county) (State) | | 24e. NAME OF FUNERAL DIRECTOR | | 24f. ADDRESS | |
| DATE REC'D BY LOCAL REG. | | REGISTRAR'S SIGNATURE | | 25. FUNERAL DIRECTOR'S SIGNATURE | |

DEC 28 1955

Carl Smith MD

Grant Johnson 4352 Wash. Blvd.

(Licensed Embalmer's Statement on Reverse Side)

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
Student Embalmer

Signed *J. A. Green*

Licensed Embalmer No. *2963*

P. O. Address *4214 Delmar*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.