

FILED FEB 17 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6280

State File No.

318

1003

717

Registrar's No.

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File 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) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 11 Days		c. CITY OR TOWN St. Louis		d. Is 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 St. Johns Hospital				e. STREET ADDRESS (If rural, give location) 3902a Shaw Ave 2179			
3. NAME OF DECEASED (Type or Print)		a. (First) Bart		b. (Middle) M.		c. (Last) Cecil Sr.	
4. DATE OF DEATH		(Month) Jan		(Day) 19		(Year) 1956	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH Mar 26 1896	
9. AGE (In years last birthday) 59		IF UNDER 1 YEAR Months _____		IF UNDER 1 YEAR Days _____		IF UNDER 1 HR. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bus Driver		10b. KIND OF BUSINESS OR INDUSTRY Pub. Ser. Co.		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo		12. CITIZEN OF WHAT COUNTRY U.S.A	
13a. FATHER'S NAME Cecil		13b. MOTHER'S MAIDEN NAME -- Gion		14. NAME OF HUSBAND OR WIFE Maxine Cecil			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) W.W.I		16. SOCIAL SECURITY NO. 494-01-1226		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Maxine Cecil 3902a Shaw Ave			
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) Cerebral Thrombosis ANTECEDENT CAUSES Arteriosclerosis Morbid 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 Conditions contributing to the death but not related to the disease or condition causing death. Hypertensive Vase Disease				INTERVAL BETWEEN ONSET AND DEATH 10 days 8 Months	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				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) 3324			
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? _____			
22. I hereby certify that I attended the deceased from July 1955 , to 1-19-1956 , that I last saw the deceased alive on 1-19-1956 and that death occurred at 4:30 P.M. , from the causes and on the date stated above.							
23a. SIGNATURE (Name or title) Carl Smith M.D.				23b. ADDRESS 18 1/2 Kingshighway		23c. DATE SIGNED 1-20-56	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 2/23/1956		24c. NAME OF CEMETERY OR CREMATORY National Cemetery		24d. LOCATION (City, town, or county) (State) Jefferson Barracks Mo	
DATE REC'D BY LOCAL REG. JAN 23 1956		REGISTRAR'S SIGNATURE Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J.L. Ziegenhein & Sons 7027 Gravois			

(Licensed Embalmer's Statement on Reverse Side)

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 *C. P. Kudwell*.....

Licensed Embalmer No. *3877*

P. O. Address *7027 Grand*

**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.**