

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

39945

FILED NOV 28 1956

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10008**

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Texas</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Sherrell</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>			Length of stay in lb <b>10 days</b>		10/0 STREET ADDRESS <b>Rural</b>		(If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)				4. DATE OF DEATH		Month Day Year		
First <b>James</b>		Middle <b>Devitt</b>		Last <b>Wrest</b>		<b>10 29 1956</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 9, 1925</b>	9. AGE (In years last birthday) <b>31</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>James Wrest</b>				14. MOTHER'S MAIDEN NAME <b>Genevieve Devitt</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Genevieve Johnson, Sherrell, Mo.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aplastic Anemia</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <del>XXXXXXXXXXXXXXXXXXXX</del>				DUE TO (c) <del>XXXXXXXX</del>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>292.4</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.								
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY STATE		
21. I attended the deceased from <b>10/19/56</b> to <b>10/29/56</b> and last saw her/him alive on <b>10/29/56</b> Death occurred at <b>1:20 a. m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>F.R. Bradley</b> (Degree or title) <b>F.R. Bradley M. D.</b>				22b. ADDRESS <b>BARNES HOSPITAL</b>		22c. DATE SIGNED <b>10/29/56</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>10-29-56</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Hutchinson Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Texas Co., Mo.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Smith-Ferguson Funeral Home, Licking, Mo.</b>				25. DATE RECD. BY LOCAL REG. <b>NOV 2 1956</b>		26. REGISTRAR'S SIGNATURE <b>Paul Smith MD</b>		

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard forms. Diseases in Part I must be casually related.

DEC 18 1957

STATEMENT BY LICENSED EMBALMER

~~XXXXXXXXXXXX~~

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 *Robert M. Murray* .....

Licensed Embalmer No. ....

P. O. Address *St. Louis* .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.  
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.