

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-034066

STATE FILE NUMBER

FILED SEP 25 1958

Registration District No.

318

Primary Registration District No.

1003

Registrar No.

8976

300  
1-57  
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All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

|   |                                   |   |                  |   |  |
|---|-----------------------------------|---|------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY  |                                   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE   |                  | b. COUNTY   |  |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br>OR TOWN  |                                   | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |                  | c. CITY OR TOWN   |  |
| c. FULL NAME OF (If NOT in hospital, give location)<br>HOSPITAL OR INSTITUTION  |                                   | Length of stay in lb  |                  | d. STREET ADDRESS (If outside, give location)   |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last  |                                   | 4. DATE OF DEATH<br>Month Day Year  |                  | Reside on Farm<br>Yes <input type="checkbox"/> No <input type="checkbox"/>                        |  |
| 5. SEX  | 6. COLOR OR RACE                  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years) UNDER 1 YEAR IF UNDER 24 HRS.<br>Month Day Year                                 |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, with If retired)   | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or 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 war or defense service)  |                                   | 16. SOCIAL SECURITY NO.   |                  | 17. INFORMANT Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a)  |                                   |   |                  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.  |                                   |   |                  | DUE TO (b)  |  |
| DUE TO (c)  |                                   |   |                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT SUICIDE HOMICIDE<br><input type="checkbox"/> <input type="checkbox"/> <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<br>Hour Month, Day, Year<br>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 _____ to _____ and last saw her alive on _____<br>Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated. |                                   |   |                  |   |  |
| 22a. SIGNATURE (Degree or title)  |                                   | 22b. ADDRESS  |                  | 22c. DATE SIGNED  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |                                   | 23b. DATE   |                  | 23c. NAME OF CEMETERY OR CREMATORY  |  |
| 24. FUNERAL DIRECTOR  |                                   | ADDRESS   |                  | 25. DATE RECD. BY LOCAL REG.  |  |
| 26. REGISTRAR'S SIGNATURE   |                                   |   |                  |   |  |

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 *V E Morris* .....

Licensed Embalmer No. *3361*

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

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.