

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, Mo.		Length of stay in 1b		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DOA CITY HOSPITAL		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 3003^a S. COMPTON	
				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last GROVER C. BOOTH			4. DATE OF DEATH Month Day Year DEC. 10 1960		
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH JAN 25 1893	9. AGE (last birthday) 67	IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN BUSINESS		11. BIRTHPLACE (City and state or country) FOREST GEORGIA	
12. CITIZEN OF WHAT COUNTRY U.S.A.					

13a. FATHER'S NAME SAM BOOTH		13b. MOTHER'S MAIDEN NAME DELANEY WATSON		14. NAME OF HUSBAND OR WIFE THERESA BOOTH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WAR I		16. SOCIAL SECURITY NO. 495-26-6459		17. INFORMANT THERESA BOOTH Address 3003^a S. COMPTON	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH 1 DAY
IMMEDIATE CAUSE (a) Coronary Occlusion			
DUE TO (b) Coronary Sclerosis			
DUE TO (c) 420.1			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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.)
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20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	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
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21. I attended the deceased from Dec. 1, 1955 to Dec. 10, 1960 and last saw ^{her} him alive on Dec. 5th 1960 Death occurred at 10 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE D. B. Javan M.D. (Degree or title)	22b. ADDRESS 539 N. Grand St. St. Louis Mo	22c. DATE SIGNED 12/12/60
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23a. BURIAL CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE DEC. 13, 1960	23c. NAME OF CEMETERY OR CREMATORY RESURRECTION CEM.	23d. LOCATION (City, town, or county) (State) ST. LOUIS Mo
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24. FUNERAL DIRECTOR Thomas Kates 2906 Gravois ADDRESS	25. DATE RECD. BY LOCAL REG. DEC 13 1960	26. REGISTRAR'S SIGNATURE Earl Smith, M.D.
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DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

Rm 401

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
 or by _____, Student Embalmer No. _____
 working under my personal supervision _____
 Student _____
 Signature of Student Embalmer

Signed E. Leonard Provin

Licensed Embalmer No. 340
 P. O. Address 2906 9th

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