

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

FILED DEC 2 1952

BIRTH NO. _____		REG. DIST. NO. 297		PRIMARY REG. DIST. NO. 6022		Registrar's No. 88	
1. PLACE OF DEATH a. CITY, COUNTY AND RURAL AND TOWN b. CITY, COUNTY AND TOWN c. LENGTH OF STAY (in this place) d. FULL NAME OF HOSPITAL OR INSTITUTION				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE b. COUNTY c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN d. STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED a. (First) b. (Middle) c. (Last) (Type or Print)		4. DATE OF DEATH (Month) (Day) (Year)		5. SEX Males (M) or Females (F)		6. COLOR OR RACE	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH (Month) (Day) (Year)		9. AGE (In years, if under 1 year: Months, Days, Hours, Min.)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (City and State or Foreign Country)		12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME	
13c. NAME OF HUSBAND OR WIFE		14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME		17. 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, asthma, etc. It means the disease, injury, or complication which caused death.			
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)	
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 4/23, 1951, to 11/22, 1952, that I last saw the deceased alive on 11/22, 1952, and that death occurred at 3:00 p.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)	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Received Nov 28th.

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 *[Signature]*

Licensed Embalmer No. *4566*

P. O. Address *[Signature] Mo.*

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