

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33450**
8281

FILED SEP 24 1953

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township)		a. STATE	
c. LENGTH OF STAY (In this place)		b. COUNTY	
d. FULL NAME OF HOSPITAL OR INSTITUTION		c. CITY (If outside corporate limits, write RURAL and give township)	
3. NAME OF DECEASED		d. STREET ADDRESS	
a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH
5. SEX		4. DATE OF BIRTH	
6. COLOR OR RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	
8. DATE OF BIRTH		9. AGE (In years, months, days)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and State or Foreign 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 by date of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME	
18. CAUSE OF DEATH		ADDRESS	
18. CAUSE OF DEATH		MEDICAL CERTIFICATION	
Enter only one cause per line for (a), (b), and (c)		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)			
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.			
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing 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?		4221	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title)		23b. ADDRESS	
23c. DATE SIGNED			
23d. BURIAL, CREMATION, REMOVAL (Specify)		23e. DATE	
24a. NAME OF CEMETERY OR CREMATORY		24b. LOCATION (City, town, or county) (State)	
24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State)	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE REC'D BY LOCAL REG.			

540

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

AUG 21 1953

J. Earl Smith, M.D.

Rowland Mortuary Service

4104 Manchester Ave.

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 Frank C. Merrick

Licensed Embalmer No. 4854

P. O. Address 4937 Forest Park

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.