

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

32608

Registration District No. 784

Primary Registration District No. 200

Registrar's No. 1841

FILED OCT 7 1941

1. PLACE OF DEATH:

(a) County St. Louis.
(b) City or town Riverview Gardens.
(If outside city or town limits, write "RURAL," and name of township)
(c) Name of hospital or institution:
10057 Dorothy Ave. /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. 3 Years. (Specify whether
In this community 3 Years. years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri. (b) County St. Louis 96
(c) City or town Riverview Gardens. (If outside city or town limits, write "RURAL")
(d) Street No. 10057 Dorothy Ave. (If rural, give location)
(e) Citizen of foreign country? 0 (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 4
year 1941. hour 12 Midnight. M.
21. I hereby certify that I attended the deceased from May 11 1941
1941 to Sept 4 1941;
that I last saw him alive on Sept 4 1941;
and that death occurred on the date and hour stated above.

Immediate cause of death. Pulmonary edema acute. Duration 5 min.
auricular fibrillation 4 mos.
Due to arteriosclerotic heart disease 7 yrs

Due to _____
Other conditions none 93d
(Include pregnancy within 3 months of death)

Major findings: none
Of operations none
Of autopsy none
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) none
(b) Date of occurrence none
(c) Where did injury occur? none (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? none

While at work? no (Specify type of place) (e) Means of injury none
23. Signature W. Stachle (M. D. or other) P. M. D.
Address 7124 Natural Bridge Date signed 9-5-41

3. (a) PRINT FULL NAME Orrin J. Read Sr.
3. (b) If veteran, name war No. 3. (c) Social Security No. N492-09-0756

4. Sex Male. 5. Color or race White. 6. (a) Single, widowed, married, divorced Married.
6. (b) Name of husband or wife Leanora Read 6. (c) Age of husband or wife if alive 55 years
7. Birth date of deceased April 2 1883
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
58 5 2 hr. min.

9. Birthplace Illinois. (City, town, or county) (State or foreign country)

10. Usual occupation Distribution Manager

11. Industry or business Star-Times.

MOTHER FATHER { 12. Name Thomas Read.
13. Birthplace Unknown. (City, town, or county) (State or foreign country)
14. Maiden name Edith Fry. (City, town, or county) (State or foreign country)
15. Birthplace Unknown. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. O. J. Read.
(b) Address 10057 Dorothy Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-8-41. (Month) (Day) (Year)
(-c) Place: burial or cremation Memorial Park Cem.

18. (a) Signature of funeral director Hy. Leidner Und. Co.
(b) Address 2223 St. Louis Ave.

19. (a) SEP - 5 1941 (Date received local registrar) (b) W. Mc (Registrar's signature)

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

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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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Homer L. Ponder

Licensed Embalmer No. 3767

P. O. Address 2223 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 this body is not embalmed, fact should be so stated above.