

1. PLACE OF DEATH:

(a) County.....
(b) City or town..... St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution..... 4311 West Pine
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community.....
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State..... Missouri (b) County..... 000
(c) City or town..... St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 19 4311 West Pine
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME

Ray A. Decker

3. (b) If veteran, name war.....

3. (c) Social Security No. 492-16-2370

4. Sex..... Male 5. Color or race..... White

6. (a) Single, widowed, married, divorced..... Married

6. (b) Name of husband or wife..... Mamie Decker

6. (c) Age of husband or wife if alive..... 60 years

7. Birth date of deceased..... November 15 1892
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
55 0 24 hr. min.

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

10. Usual occupation..... Shoe Worker

11. Industry or business.....
12. Name..... William Decker

13. Birthplace..... Bland Missouri
(City, town, or county) (State or foreign country)

14. Maiden name..... Unknown

15. Birthplace..... Unknown
(City, town, or county) (State or foreign country)

16. (a) Informant..... Mamie Decker
(b) Address..... 4311 West Pine

17. (a) Burial (b) Date thereof..... 12-12-47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation..... Belle, Mo.

18. (a) Signature of funeral director..... Albert H. Hoppe
(b) Address..... 4700 Washington Blvd.

19. (a) DEC 10 1947 (b) J. F. Brunick
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... Dec. day..... 9
year..... 1947 hour..... 2 minute..... 15 P.M.

21. I hereby certify that I attended the deceased from..... Sept 1947
..... 19..... 17, to..... December 9..... 19..... 47;
that I last saw him alive on..... December 9..... 19..... 47
and that death occurred on the date and hour stated above.

Immediate cause of death..... Crown Aneurysm

Due to.....
Due to.....

Other conditions.....
(include pregnancy within 3 months of death)

Major findings:
Of operations.....
Of autopsy.....

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify).....
(b) Date of occurrence.....
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?..... (Specify type of place)
While at work?..... (e) Means of injury.....
23. Signature..... W. B. Stanger M.D. (M. D. or other)
Address..... 721 N. Kingshighway Date signed..... 12/10/47

Duration
PHYSICIAN
Underline the cause of which death should be charged statistically.

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

MOTHER FATHER

None

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 *Elmo R. Sadwell*

Licensed Embalmer No. 4077

P. O. Address _____

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.