

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED APR 1 1949

State File No. 2524
Registrar's No.

BIRTH NO. 49-017830 REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

No. 300
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH a. COUNTY MISSOURI			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE ILLINOIS		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS		c. LENGTH OF STAY (in this place) 0	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN EAST ST. LOUIS		d. STREET ADDRESS (If rural, give location) 1738 OHIO AVE.
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. LOUIS MATERNITY HOSPITAL					

3. NAME OF DECEASED (Type or Print) a. (First) JOHN		b. (Middle) MICHAEL		c. (Last) DEGENHART		4. DATE OF DEATH (Month) (Day) (Year) MARCH 18 49		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) U		8. DATE OF BIRTH MARCH 17 49		9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ST. LOUIS, MISSOURI			12. CITIZEN OF WHAT COUNTRY?	

13a. FATHER'S NAME WILLARD DEGENHART		13b. MOTHER'S MAIDEN NAME MARIE KATHERYN JUDD		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME 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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Intracranial Pressure					
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hydrocephalus 159					
		DUE TO (c) Congenital					
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Immaturity 7/16					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) m.		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 3/17, 1949, to 3/18, 1949, that I last saw the deceased alive on 3/18, 1949, and that death occurred at 4:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) J.P. McNeely M.D. (1)		23b. ADDRESS 3720 Washington		23c. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 3-19-49		24c. NAME OF CEMETERY OR CREMATORY Valhalla	
24d. LOCATION (City, town, or county) (State) Belleville Ill		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS W. H. Hurrington East St. Louis			
DATE REC'D BY LOCAL REG. APR 21 1949		REGISTRAR'S SIGNATURE J.P. Lasater			

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.

Signed _____
Student Embalmer

Signed _____

Licensed Embalmer No. 3162

P. O. Address St. Louis, Ill

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.