

No. 300
10.48

FILED APR 15 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

10771
State File No. 3165

318 1003

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST. LOUIS MO</u>				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>AFTON</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ALEXIAN BROS Hosp</u>				d. STREET ADDRESS (If rural, give location) <u>8907 VAL COUR</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>CHARLES</u>		b. (Middle) <u>A.</u>		c. (Last) <u>VIDOT</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>APRIL 1 1949</u>	
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>MAY 13 1891</u>	
9. AGE (In years last birthday) <u>57</u>		10. UNDER 1 YEAR Months <u>10</u> Days <u>7</u>		11. BIRTHPLACE (State or foreign country) <u>ST. LOUIS MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BAKERS SUPPLY</u>		11. BIRTHPLACE (State or foreign country) <u>ST. LOUIS MO</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>AUGUST VIDOT</u>		13b. MOTHER'S MAIDEN NAME <u>MARIE KINDERSTUPE</u>		14. NAME OF HUSBAND OR WIFE <u>LUCILLE VIDOT</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. <u>IP.</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>LUCILLE VIDOT 8907 VAL COUR</u>			
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.		V MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (a) <u>acute cardiac dilatation</u> ANTECEDENT CAUSES <u>Ch. Myocarditis, initial</u> Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. <u>regurgitation</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Asites due to cardiac failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>15 mos.</u> <u>11 mos.</u> <u>5 mos</u>	
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION <u>none</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE (Specify) <u>NO</u>		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 checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>Oct 20, 1947</u> to <u>Apr. 1, 1949</u> , that I last saw the deceased alive on <u>April 1, 1949</u> , and that death occurred at <u>1:30 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>W. J. Ingleclauhek MD</u> (Degree or title)				23b. ADDRESS <u>2767 Garrison St</u>		23c. DATE SIGNED <u>4-2-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>APRIL 5, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>ST. PAUL CHURCHYARD</u>		24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO</u>	
DATE REC'D BY LOCAL REG. <u>APR 4</u>		REGISTRAR'S SIGNATURE <u>J. B. Sasator</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Thomas Kutis 2906 Garrison</u>			

WRITE PLAINLY—USING 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.....

..... Student Embalmer No.
working under my personal supervision.

Student
Student Embalmer

Signed *Harmon C. Will*.....

Licensed Embalmer No. *4347*.....

P. O. Address *2906 Davenport*.....

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.