

FILED JUN 16 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. 20971  
4943

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Saint Louis, Mo.</b>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Saint Louis</b>		179	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>5710 West Park</b>				d. STREET ADDRESS (If rural, give location) <b>5710 West Park</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>Roy</b>		b. (Middle) <b>E.</b>		c. (Last) <b>Drysdale</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>June 4th, 1949</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Jan. 10th, 1924</b>		9. AGE (In years last birthday) <b>25</b> IF UNDER 1 YEAR: Months <b>4</b> Days <b>24</b> IF UNDER 2 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Leatherworker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>James Murphy Leather Company</b>		11. BIRTHPLACE (State or foreign country) <b>Saint Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>James Drysdale</b>		13b. MOTHER'S MAIDEN NAME <b>Metta Yount</b>		14. NAME OF HUSBAND OR WIFE <b>Nina M. Drysdale, nee McCurry</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes World War # 2</b>		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Nina M. Drysdale, 5710 West Park</b>			
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.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Malignant tumor of frontal lobe of brain</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION <b>Sept 1947</b>		19b. MAJOR FINDINGS OF OPERATION <b>Carcinoma of frontal lobe of brain</b>				20. AUTOPSY? YES <input 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, etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) _____ (STATE) <b>546</b>		193X	
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? _____			
22. I hereby certify that I attended the deceased from <b>Sept 1947</b> to <b>June 4, 1949</b> , that I last saw the deceased alive on <b>June 3, 1949</b> , and that death occurred at <b>11:30 A.M.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Paul H. Dermatorff M.D.</b>				23b. ADDRESS <b>3919 W. Florissant</b>		23c. DATE SIGNED <b>6/4/49</b>	
24a. BURIAL OR CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>6/7/49</b>		24c. NAME OF CEMETERY OR CREMATORY <b>New Saint Marcus Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>Saint Louis, Missouri</b>	
DATE REC'D BY LOCAL REG. <b>JUN 9 1949</b>		REGISTRAR'S SIGNATURE <b>J. B. Fosater</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Calvin F. Feutz, 4828 Natural Bridge Blvd.</b>			

(Licensed Embalmer's Statement on Reverse Side)

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

CAIWEITH 108D,  
Near Florissant, Missouri,  
Phone Victor 7-1145

**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.....

.....  
working under my personal supervision.

Student Embalmer No. ....

Student .....  
Student Embalmer

Signed J. Allen Davis, Jr.

Licensed Embalmer No. 40531

P. O. Address 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.