

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25361

State File No. _____

FILED AUG 13 1949
53927-49

REG. DIST. NO. 318

PRIMARY REG. DIST. NO. 1003

Registrar's No. 6798

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo		c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		d. STREET ADDRESS (If rural, give location) 5721 Labadie	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. John's Hospital			4. DATE OF DEATH (Month) (Day) (Year) August 3, 1949			
3. NAME OF DECEASED (Type or Print) a. (First) Michael b. (Middle) Viehland c. (Last)			5. SEX Male			
6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH August 3, 1949		9. AGE (In years last birthday) if UNDER 1 YEAR Months Days if UNDER 1 Hrs. Min. 7 5	
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 Mr. Leonard Viehland		13b. MOTHER'S MAIDEN NAME Cecelia Laura Hoven		14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME Leonard Viehland		ADDRESS 5721 Labadie	
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) Immaturity ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Delivery at 6 mo gestation 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 7 hrs 5 min
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) 1579		21f. HOW DID INJURY OCCUR 77% X	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22. I hereby certify that I attended the deceased from Aug 3, 1949, to Aug 3, 1949, that I last saw the deceased alive on Aug 3, 1949, and that death occurred at 11:40 m., from the causes and on the date stated above.			
23a. SIGNATURE Dr. C.N. Lindeman		(Degree or title) M.D.	23b. ADDRESS 4176 ^a Shrew		23c. DATE SIGNED Aug 4 1949	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8/5/49	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.		
DATE REC'D BY LOCAL HEALTH DEPT. AUG 5 1949		REGISTRAR'S SIGNATURE J. B. Lassater		25. FUNERAL DIRECTOR'S SIGNATURE Drehmann-Harrel - 1905 Union Blvd.		

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

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 Warren A. Carver

Licensed Embalmer No. 3534

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.