

FILED SEP 6 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 28765

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>2062</u>		Registrar's No. <u>1944</u>			
1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>					
b. CITY (If outside corporate limits, write RURAL and give town) <u>Maplewood</u>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <u>Maplewood</u>		d. STREET ADDRESS (If rural, give location) <u>2022 Hiawatha</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>2022 Hiawatha Ave.</u>				d. STREET ADDRESS (If rural, give location) <u>2022 Hiawatha</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Harry B.</u> b. (Middle) <u>B.</u> c. (Last) <u>Decker</u>			4. DATE OF DEATH <u>Aug. 10, 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>August 28, 1867</u>			
9. AGE (In years last birthday) <u>81</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>St. Louis, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>Decker</u>			13b. MOTHER'S MAIDEN NAME <u>Bruens</u>			14. NAME OF HUSBAND OR WIFE <u>Veronica Byrne Decker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Veronica Decker 2022 Hiawatha Ave.</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, asthenia, 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) <u>arteriosclerotic heart disease</u>				DUPLICATE OF (a) <u>arteriosclerotic heart disease</u>				<u>years</u>	
ANTECEDENT CAUSES				DUPLICATE OF (b) <u>Generalized arteriosclerosis</u>				<u>years</u>	
Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.				DUPLICATE OF (c) _____					
II. OTHER SIGNIFICANT CONDITIONS				Conditions contributing to the death but not related to the disease or condition causing death.				<u>4/300</u>	
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) _____					
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 <u>Aug. 9, 1949</u> , to <u>Aug 10, 1949</u> , that I last saw the deceased alive on <u>Aug 10, 1949</u> , and that death occurred at <u>8 A. M.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>May J. Franklin M.D.</u> (Degree or title)				23b. ADDRESS <u>634 U. Grand</u>		23c. DATE SIGNED <u>8/11/49</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Aug 12, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>(St. Louis, Missouri)</u>			
DATE REC'D BY LOCAL REG. <u>8-12-49</u>		REGISTRAR'S SIGNATURE <u>Headmaster R. ...</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>M. J. ...</u>					

(Licensed Embalmer's Statement on Reverse Side)

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

M-52

*Dr. Med. Embalmers
-no. 1111111111*

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 J. Allen Davis Jr.

Licensed Embalmer No. 4053

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.