

FILED SEP 20 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31736
Registrar's No. 7847

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1002

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|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY ST. LOUIS | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo. | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Pine Lawn | |
| c. LENGTH OF STAY (in this place) | | d. STREET ADDRESS (If rural, give location) 32 Blakemore Place | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Firmin Desloge Hospital | | | |

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|-------------------------------------|--------------------------|-------------|-------------------------|---|
| 3. NAME OF DECEASED (Type or Print) | a. (First) Joseph | b. (Middle) | c. (Last) Enders | 4. DATE OF DEATH (Month) (Day) (Year) 9-9-49 |
|-------------------------------------|--------------------------|-------------|-------------------------|---|

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|--------------------|-------------------------------|---|---------------------------------|---|------------------------|-----------------------|-----------------------|------|
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH 9-12-80 | 9. AGE (In years last birthday) 68 | IF UNDER 1 YEAR Months | IF UNDER 24 HRS. Days | IF UNDER 2 HRS. Hours | Min. |
|--------------------|-------------------------------|---|---------------------------------|---|------------------------|-----------------------|-----------------------|------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired laborer | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Missouri | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
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| 13a. FATHER'S NAME John Enders | 13b. MOTHER'S MAIDEN NAME Maggie Miochimer | 14. NAME OF HUSBAND OR WIFE Kate Connolly |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | 16. SOCIAL SECURITY NO. | 17. INFORMANT'S SIGNATURE OR NAME | ADDRESS |
|---|-------------------------|-----------------------------------|---------|

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| 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 | | INTERVAL BETWEEN ONSET AND DEATH 2 yrs. |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myelogenous leukemia | | |
| | ANTECEDENT CAUSES Morbidity 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. arteriosclerotic heart disease Generalized arteriosclerosis | | Unknown | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
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| 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) 74W |
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| | | |
|--|--|--|
| 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"/> | 21f. HOW DID INJURY OCCUR? 204H |
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22. I hereby certify that I attended the deceased from **6-20-49**, 19____, to **9-9-49**, 19____, that I last saw the deceased alive on **9-9-49**, 19____, and that death occurred at **9:20 A.M.**, from the causes and on the date stated above.

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| 23a. SIGNATURE (Degree or title) Burnet W. Pedew, M.D. | 23b. ADDRESS Firmin Desloge Hosp. 1325 So. Grand Ave. | 23c. DATE SIGNED 9/9/49 |
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| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE Sept. 12, 1949 | 24c. NAME OF CEMETERY OR CREMATORY Calvary | 24d. LOCATION (City, town, or county) (State) St. Louis Mo. |
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| DATE REC'D BY LOCAL REG. SEP 10 1949 | REGISTRAR'S SIGNATURE [Signature] | 25. FUNERAL DIRECTOR'S SIGNATURE Sullivan Bros | ADDRESS 2849 N. Euclid |
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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.....

.....
working under my personal supervision.

Student
Student Embalmer

Student Embalmer No.

Signed

Robert L. Brinkman

Licensed Embalmer No.

3553

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.