

FILED OCT 13 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

31817

318

1003

State File No. _____

Registrar's No. 8502

BIRTH NO. _____		REG. DIST. NO. <u>318</u>	PRIMARY REG. DIST. NO. <u>1003</u>
1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Illinois</u> b. COUNTY <u>Franklin</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>East St. Louis</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Lukes Hospital</u>		d. STREET ADDRESS (If rural, give location) <u>1231 N. 48th St.</u>	
3. NAME OF DECEASED (Type or Print) a. (First) <u>Ralph</u> b. (Middle) _____ c. (Last) <u>Haslip</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Sept. 29, 1949</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Feb. 21, 1895</u>
9. AGE (In years last birthday) <u>54</u>		10. F UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steam Fitter</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <u>Collinsville, Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13a. FATHER'S NAME <u>John Haslip</u>		13b. MOTHER'S MAIDEN NAME <u>Laura Owens</u>	
14. NAME OF HUSBAND OR WIFE <u>Never Married</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____	
16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>William L. Cudd</u> ADDRESS <u>1231 N. 48th St.</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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchiogenic Carcinoma</u> 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. <u>Constrictive pericarditis</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input checked="" 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 bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) <u>Mo</u>	
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 _____		162X	
22. I hereby certify that I attended the deceased from <u>Sept. 20, 1949</u> , to <u>Sept. 29, 1949</u> , that I last saw the deceased alive on <u>Sept. 29, 1949</u> , and that death occurred at <u>2:30 p.m.</u> , from the causes and on the date stated above.			
23a. SIGNATURE <u>Geo. W. Stuebel M.D.</u> (Degree or title)		23b. ADDRESS <u>3720 Washington Blvd.</u>	
23c. DATE SIGNED <u>9-30-49</u>		24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	
24b. DATE <u>9-30-49</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Masonic & Oddfellows</u>	
24d. LOCATION (City, town, or county) (State) <u>Benton, Ill.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Albert H. Hoppe</u> ADDRESS <u>4700 Washington Blvd.</u>	
DATE REC'D BY LOCAL REG. <u>10-3-49</u>		REGISTRAR'S SIGNATURE <u>J. B. Susater</u>	

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

MAR 7 1950

SEP 26 1950

Frank

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. Wm. Dinkley*

Licensed Embalmer No. *3653*

P. O. Address *St. Louis Mo*

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.