

FILED NOV 10 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 35131

Registrar's No. 9304

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1002		Registrar's No. 9304			
1. PLACE OF DEATH a. COUNTY —				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY 91.					
b. CITY (If outside corporate limits, write RURAL and give townshp.) OR TOWN St. Louis, Missouri		c. LENGTH OF STAY (in this place) ( ) 24 hrs.		c. CITY (If outside corporate limits, write RURAL and give townshp.) OR TOWN University City		3 5-			
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Barnes Hospital				d. STREET ADDRESS (If rural, give location) N.R. 714 Kingsland Ave.					
3. NAME OF DECEASED (Type or Print) a. (First) Sam		b. (Middle)		c. (Last) Floun		4. DATE OF DEATH (Month) (Day) (Year) Oct. 27, 1949			
5. SEX Male ( )		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single ( )		8. DATE OF BIRTH Unknown			
9. AGE (In years last birthday) Apt. 46		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Mins.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive		10b. KIND OF BUSINESS OR INDUSTRY Real Estate		11. BIRTHPLACE (State or foreign country) St. Louis, Mo. ( )		12. CITIZEN OF WHAT COUNTRY?			
13a. FATHER'S NAME Harry Floun			13b. MOTHER'S MAIDEN NAME Ida Rich			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 ADDRESS Dorothy Floun-714 Kingsland					
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute anterior myocardial infarction  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		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) 9400					
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? 4281					
22. I hereby certify that I attended the deceased from Oct. 26, 1949, to Oct. 27, 1949, that I last saw the deceased alive on Oct. 27, 1949, and that death occurred at 9:40 P.m., from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) F. Bralley M.D.				23b. ADDRESS Barnes Hospital,		23c. DATE SIGNED 10/28/49			
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10/30/49		24c. NAME OF CEMETERY OR CREMATORY Chesed Shel Emeth Cem.		24d. LOCATION (City, town, or county) (State) St. Louis, Mo.			
DATE REC'D BY LOCAL REG. OCT 29 1949		REGISTRAR'S SIGNATURE J. B. Sabater			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Herman Rando, Inc - 5716 Delmar				

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

MAY 30 1946

**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 \_\_\_\_\_

*John Kettes*  
Licensed Embalmer No. 3880

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.