

FILED DEC 14 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **39001**
10375BIRTH NO. 104806 REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10375**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Mo.		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1.		d. STREET ADDRESS (If rural, give location) 3912 Childress	
3. NAME OF DECEASED (Type or Print) a. (First) VINCENT b. (Middle) c. (Last) LOPEZ		4. DATE OF DEATH (Month) (Day) (Year) Nov. 30th, 1949	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 19 1862
9. AGE (In years last birthday) 87		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) Elevator Operators		10b. KIND OF BUSINESS OR INDUSTRY Pharmaceutical Mfg	11. BIRTHPLACE (State or foreign country) Leon, Mexico
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME Louis Lopez	
13b. MOTHER'S MAIDEN NAME Petra (Unknown)		14. NAME OF HUSBAND OR WIFE Wilhelmina Linder Lopez	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes, give year or date of service) No		16. SOCIAL SECURITY NO. 498-07-4101	17. INFORMANT'S SIGNATURE OR NAME Mrs. Wilhelmina Lopez, 3912 Childress
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 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Emboli & 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. Mechanical bowel obstruction	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION due to adhesions	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) 12th	
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? 579X	
22. I hereby certify that I attended the deceased from 11/25/49 , 19___, to 11/30/49 , 19___, that I last saw the deceased alive on 11/30/49 , 19___, and that death occurred at 2:45 PM , from the causes and on the date stated above.			
23a. SIGNATURE Albert Repetto		23b. ADDRESS 1515 Lafayette Ave.,	23c. DATE SIGNED 11/30/49
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Dec. 3, 1949	24c. NAME OF CEMETERY OR CREMATORY St. Matthew's Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri
DATE RECD BY LOCAL OFFICE DEC 2 1949	REGISTRAR'S SIGNATURE J. B. Lasater	25. FUNERAL DIRECTOR'S SIGNATURE Beiderwieden F.H. Inv. 1936 St. Louis Ave.	

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 _____

Max L. Warfel

Licensed Embalmer No. 4170

P. O. Address 1936 St. Louis Ave.

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.