

FILED MAR 4 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1534

No. 300
10-48

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis		a. STATE Mo	b. COUNTY
c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Park Lane Hospital		d. STREET ADDRESS (If rural, give location) 6737 Fyler	

3. NAME OF DECEASED (Type or Print)	a. (First) Abram	b. (Middle) H	c. (Last) Black	4. DATE OF DEATH (Month) (Day) (Year) Feb. 16, 1950
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Jan 19, 1880	9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months	IF UNDER 2 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Florist	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) St Louis, Mo.	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME Black	13b. MOTHER'S MAIDEN NAME Martha	14. NAME OF HUSBAND OR WIFE Alma-Black
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Alma Black	ADDRESS 6737 Fyler
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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 1 year.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Decompensation		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Cardio-renal failure		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) H H 2 X
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from July, 1949, to Feb. 16, 1950, that I last saw the deceased alive on Feb 16, 1950, and that death occurred at 1:55 P. m., from the causes and on the date stated above.

23a. SIGNATURE NB Kappesser, M.D.	(Degree or title)	23b. ADDRESS 3284 Ivanhoe	23c. DATE SIGNED 2-17-50.
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24a. BURIAL, CREMATION, REMOVAL (Specify) burial	24b. DATE 2/20/50	24c. NAME OF CEMETERY OR CREMATORY 0 St Marcus Cemetery	24d. LOCATION (City, town, or county) (State) St Louis, Mo.
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DATE REC'D BY LOCAL REG. FEB 20 1950	REGISTRAR'S SIGNATURE J B Laster	25. FUNERAL DIRECTOR'S SIGNATURE Ziegenhein & Sons	ADDRESS 7027 Gravois
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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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Frank J. Owen

Licensed Embalmer No. 2245

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.