

FILED MAY 10 1950

## STANDARD CERTIFICATE OF DEATH

State File No. 13078

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 4051

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) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2089	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Johns Hospital		d. STREET ADDRESS (If rural, give location) 1758 Grape Ave. 0	
3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) D. c. (Last) Van Scoyk			4. DATE OF DEATH (Month) (Day) (Year) May 3, 1950.
5. SEX male 0	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widower 2	8. DATE OF BIRTH Oct. 9, 1857
9. AGE (In years last birthday) 92		10. KIND OF BUSINESS OR INDUSTRY	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		11. BIRTHPLACE (State or foreign country) Iowa	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME unknown	
13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE deceased	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Mr. W. V. Van Scoyk		ADDRESS 1758 Grape Ave.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)			
MEDICAL CERTIFICATION			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ac Myocardial Decompensation		INTERVAL BETWEEN ONSET AND DEATH 10 days	
ANTECEDENT CAUSES *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death. Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension Cordis-Vas-Renalis DUE TO (c)		16 yrs	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cerebral Thrombosis		2 yrs	
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) H/H/H X			
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?			
22. I hereby certify that I attended the deceased from June, 1940, to May 3, 1950, that I last saw the deceased alive on May 3, 1950, and that death occurred at 2:30 p.m., from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) Dr. C. N. Lindeman M.D.		23b. ADDRESS 4126 Shrew Ave.	
23c. DATE SIGNED 5/4/50			
24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE 5-5-50	
24c. NAME OF CEMETERY OR CREMATORY City Cemetery		24d. LOCATION (City, town, or county) (State) via rail Goodland, Kansas	
DATE REC'D BY LOCAL REG. MAY 4 1950		REGISTRAR'S SIGNATURE Math Hermann & Son, Inc.	
25. FUNERAL DIRECTOR'S SIGNATURE Math Hermann & Son, Inc.		ADDRESS 2161 E. Fair Ave.	

(Licensed Embalmer's Statement on Reverse Side)

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

No. 300  
10.48

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.

Signed.....  
Student Embalmer

Signed

Student Embalmer No.....  
*Glen W. Hayes*

Licensed Embalmer No. *3757*

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.