No. 300
10.48

FILED MAY 13 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15417

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 1083

1. PLACE OF DEATH
a. COUNTY: Koch Hosp. Koch, Mo.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Koch
c. LENGTH OF STAY (in this place): 78 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Koch Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis 2119
d. STREET ADDRESS (If rural, give location): 4230 A Fairfax

3. NAME OF DECEASED (Type or Print)
a. (First): Herman
b. (Middle):
c. (Last): Logan

4. DATE OF DEATH (Month) (Day) (Year): 4-22-50

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 9-4-84
9. AGE (In years last birthday): 65 — 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): Mover
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Fulton, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME: Lucian Porter
13b. MOTHER'S MAIDEN NAME: Hanna Johnson
14. NAME OF HUSBAND OR WIFE: Thresa Campbell

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.: yes
17. INFORMANT'S SIGNATURE OR NAME: Thomas H Boldt — ADDRESS: Koch Hosp.

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) Pulmonary Tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 3 mos.

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.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: 002X
20. AUTOPSY? YES ☐ NO ☒

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):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-1, 1950, *to* 4-22, 1950, *that I last saw the deceased alive on* 4-22, 1950, *and that death occurred at* 12:44 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Thomas H. Boldt MD
23b. ADDRESS: Koch Hosp Koch Mo
23c. DATE SIGNED: 4/23/50

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 4/28/50
24c. NAME OF CEMETERY OR CREMATORY: Greenwood Cemetery
24d. LOCATION (City, town, or county) (State): St. Louis, Missouri

DATE REC'D BY LOCAL REG.: APR 27 1950
REGISTRAR'S SIGNATURE: Herbert R. Domke MD
25. FUNERAL DIRECTOR'S SIGNATURE: Chas. J. Gates, 4107 Finney Avenue — ADDRESS

(Licensed Embalmer's Statement on Reverse Side)

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 John K. Cunningham

Licensed Embalmer No. 4476

P. O. Address 4107 Finney Avenue

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.