

FILED JUL 5 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

21422
State File No. 5585

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY D				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. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		2139 0	
d. FULL NAME OF HOSPITAL OR INSTITUTION Dealoge Hospital				d. STREET ADDRESS (If rural, give location) 3370 Commonwealth Ave			
3. NAME OF DECEASED (Type or Print) a. (First) Clarence b. (Middle) W. c. (Last) Cale			4. DATE OF DEATH (Month) (Day) (Year) 6-25-1950				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH 6-18-1881		9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 4 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Engineer		10b. KIND OF BUSINESS OR INDUSTRY Frisco R.R.		11. BIRTHPLACE (State or foreign country) Kansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME Daniel W. Cale		13b. MOTHER'S MAIDEN NAME Mary Smith		14. NAME OF HUSBAND OR WIFE Minnie Cale			
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. None		17. INFORMANT'S SIGNATURE OR NAME Minnie Cale ADDRESS 3370 Commonwealth Av			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac decompensation ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Arteriosclerotic C.V.R. disease 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. none					INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
19a. DATE OF OPERATION _____	19b. MAJOR FINDINGS OF OPERATION none					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) no		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) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? H2X			
22. I hereby certify that I attended the deceased from Apr 19 48 , to June 25, 19 50 , that I last saw the deceased alive on June 25, 19 50 , and that death occurred at 11:15 P. m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Dallas J. Dyer, M.D., A.S. Oppenheimer, M.D., Hampton W. Med. Center, St. Louis, Mo.				23b. ADDRESS D. J. Dyer, M.D.		23c. DATE SIGNED June 27, 1950	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial ()		24b. DATE 6-28-1950	24c. NAME OF CEMETERY OR CREMATORY Lake Charles Cemetery		24d. LOCATION (City, town, or county) (State) 7775 St. Charles Rock Road Mo		
DATE REC'D BY LOCAL REG. JUN 27 1950		REGISTRAR'S SIGNATURE J. B. Pasater		25. FUNERAL DIRECTOR'S SIGNATURE Ziegenhain Bros ADDRESS 6409 Gravois Ave			

Dr. Oppenheimer Metropolitan Bldg
NE 8512 11 to 2
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

MUST

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: *Henry M. Brammer*

Licensed Embalmer No. *4200*

P. O. Address. *St. Louis.*

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.