

FILED JUL 29 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24712
6130
Registrar's No.

318

1003

BIRTH NO.		REG. DIST. NO.		PRIMARY REG. DIST. NO.		Registrar's No.	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis		2014	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Lutheran Hospital				/d. STREET ADDRESS (If rural, give location) 6639 Virginia Ave			
3. NAME OF DECEASED (Type or Print) Edward Drozda			4. DATE OF DEATH (Month) (Day) (Year) July 17 1950				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Div.		8. DATE OF BIRTH Jan. 1st. 63	
9. AGE (In years last birthday) 15		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Clerk		11. BIRTHPLACE (State or foreign country) Mo.	
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME Edward		13b. MOTHER'S MAIDEN NAME Minnie ?		14. NAME OF HUSBAND OR WIFE Unknown	
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. 490 22 4196		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Lorraine Cunningham 6639 Virginia			
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) Diabetes Mellitus 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. Carcinoma of right main bronchus 3 mo				INTERVAL BETWEEN ONSET AND DEATH 10 years	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION Metastases to hilus lymph nodes				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)			
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? 2nd floor			
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19 50 , that I last saw the deceased alive on July , 19 50 , and that death occurred at 2.4 p.m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Walter J. Liebert M.D.				23b. ADDRESS		23c. DATE SIGNED	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE July 20 1950		24c. NAME OF CEMETERY OR CREMATORY New Picker		24d. LOCATION (City, town, or county) (State) St. Louis	
DATE REC'D BY SOCIAL REG. JUL 17 1950		REGISTRAR'S SIGNATURE J. B. Lanter		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Fendler Und Co 7420 Michigan			

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

19 - July -

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 *H. M. M. M.* _____

Licensed Embalmer No. 3260 _____

P. O. Address _____

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.