

FILED AUG-10 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 24810

#112621

318

1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. 6470

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) OR TOWN St. Louis, Mo. c. LENGTH OF STAY (in this place) _____
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis 2259

d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital #1. STREET ADDRESS (If rural, give location) 1300 N. Broadway

3. NAME OF DECEASED a. (First) THEODORE b. (Middle) _____ c. (Last) GRECK 4. DATE OF DEATH (Month) (Day) (Year) July 28th, 1950

5. SEX Male 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single 8. DATE OF BIRTH 5-14-82 9. AGE (In years last birthday) 67 if under 1 year Months _____ Days _____ if under 12 mos. Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 10b. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE (State or foreign country) Missouri 12. CITIZEN OF WHAT COUNTRY? _____

13a. FATHER'S NAME Z. Greck 13b. MOTHER'S MAIDEN NAME Unknown 14. NAME OF HUSBAND OR WIFE _____

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) _____ 16. SOCIAL SECURITY NO. none 17. INFORMANT'S SIGNATURE OR NAME Dorothy Skalas ADDRESS 627 Beatrice

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) MEDICAL CERTIFICATION Lemay, Mo. INTERVAL BETWEEN ONSET AND DEATH 34 days
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia
ANTECEDENT CAUSES DUE TO (b) Hypertrophy of prostate 2 yrs
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS Arteriosclerotic Heart disease
*This does not mean the mode of dying, such as heart failure, asphyxia, 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.
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 7-26-50 19b. MAJOR FINDINGS OF OPERATION Hypertrophy of prostate 20. AUTOPSY? YES NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____ 21b. PLACE OF INJURY (City, town, or village, home, farm, factory, street, office building, etc.) _____ 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? 101DX

22. I hereby certify that I attended the deceased from 7/1/50 1950 to 7/28/50, 1950, that I last saw the deceased alive on 7/28/50, 1950, and that death occurred at 12:40 am on 7/28/50, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) William W. Carter M.D. 23b. ADDRESS 1515 Lafayette Ave., 23c. DATE SIGNED 7/28/50

24a. BURIAL, CREMATION, REMOVAL (Specify) _____ 24b. DATE 7-31-50 24c. NAME OF CEMETERY OR CREMATORY Mt. Hope 24d. LOCATION (City, town, or county) (State) Lemay, Mo.

DATA REC'D BY LOCAL REG. Busial REGISTRAR'S SIGNATURE J. B. Sauter 25. GENERAL DIRECTOR'S SIGNATURE J. P. [Signature] P. ADDRESS 7420 Michigan Ave.

JUL 28 1950

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

A

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.

Student Embalmer No.....

Signed.....

V E Moore

Signed.....
Student Embalmer

Licensed Embalmer No. *3360*

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.