

No. 300
10-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25222

FILED JUL 29 1950

State File No. 6160

REG. DIST. NO. 318

1003

Registrar's No.

BIRTH NO.		REG. DIST. NO. 318		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			
b. CITY (If outside corporate limits, write RURAL and give OR TOWN)				c. CITY (If outside corporate limits, write RURAL and give township)			
d. FULL NAME OF HOSPITAL OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or Print) a. (First)		b. (Middle)		c. (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
5. SEX		6. COLOR OR RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH	
9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Days		IF UNDER 2 WRS. Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		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)		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?		22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ A. M., from the causes and on the date stated above.		23a. SIGNATURE (Degree or title)	
23b. ADDRESS		23c. DATE SIGNED		24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE	
24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State)		DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		JUL 18 1950		(Licensed Embalmer's Statement on Reverse Side)	

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

7 Hwy - Cal. Cal. Cal. - 3606 Garrison St. - St. Louis, Mo. - 25222

MEDICAL CERTIFICATION

1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) *Chronic myocarditis - Senility* INTERVAL BETWEEN ONSET AND DEATH *years*

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) *Arteriosclerosis* *years*

DUE TO (c) *Ch. Cholelithiasis*

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. *Parkinsonism*

42 20

July 17-50

J. B. Roser Registrar
Fiegenheim Bros. 6409 Gravois Ave

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 Me

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed Elton H. Remelius

Licensed Embalmer No. 4283

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.