

FILED SEP 15 1950

STANDARD CERTIFICATE OF DEATH

88118
State File No. 7513

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		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) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) Flat River 0942	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony's Hospital		d. STREET ADDRESS (If rural, give location) 100 Science St. /	

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) Samuel c. (Last) DeGuire			4. DATE OF DEATH (Month) (Day) (Year) Sept. 1 1950		
5. SEX male		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH Jan. 21, 1870			9. AGE (In years last birthday) 80		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Millworker			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) Fredericktown, Mo.			12. CITIZEN OF WHAT COUNTRY? U.S.		

13a. FATHER'S NAME William DeGuire		13b. MOTHER'S MAIDEN NAME Cordelia Yalalay		14. NAME OF HUSBAND OR WIFE Edith	
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 ADDRESS Edith DeGuire, Flat River, Mo.	

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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ARTERIO-SCLEROTIC HEART DISEASE WITH DECOMPENSATION ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) ARTERIO-SCLEROSIS GENERALIZED DUE TO (c) — II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH UNK UNK	
---	--	---	--	--	--

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input 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)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 4200	

22. I hereby certify that I attended the deceased from 8-16-1950, to 9-1-1950, that I last saw the deceased alive on 9-1-1950, and that death occurred at 6:45P m., from the causes and on the date stated above.

23a. SIGNATURE Robert G. Warner MD		23b. ADDRESS Paul Brunsfeld		23c. DATE SIGNED 2-Sept 1950	
24a. BURIAL, CREMATION, REMOVAL (Specify) removal		24b. DATE Sept. 2, 50		24c. NAME OF CEMETERY OR CREMATORY St. Francois Catholic	
24d. LOCATION (City, town, or county) (State) St. Francois, Mo.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS H. Albert H. Hoppe, 4700 Washington			
DATE REC'D BY LOCAL REG. SEP 5 1950		REGISTRAR'S SIGNATURE J. B. Faraster			

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 me

.....
working under my personal supervision.

Student Embalmer No.

Signed *W. L. Salter*

Signed.....
Student Embalmer

Licensed Embalmer No. 4699

P. O. Address St. Charles, 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.