

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 23 1950

State File No. 28199
Registrar's No. 6806

BIRTH NO.		REG. DIST. NO. 318		PRIMARY REG. DIST. 1003		Registrar's No. 6806	
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		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR Town St. Louis		2019	
d. FULL NAME OF HOSPITAL OR INSTITUTION Alexian Bros. Hosp				d. STREET ADDRESS (If rural, give location) 7600 Reilly Ave. 0			
3. NAME OF DECEASED (Type or Print) Joseph		a. (First)		b. (Middle)		c. (Last) Garcia	
4. DATE OF DEATH (Month) (Day) (Year) Aug. 8, 1950		5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	
8. DATE OF BIRTH Apr. 10, 1884		9. AGE (In years last birthday) 66		IF UNDER 1 YEAR Month Day		IF UNDER 24 HRS. Hour 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) Spain		12. CITIZEN OF WHAT COUNTRY? 5	
13a. FATHER'S NAME ? Garcia		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Marie Garcia			
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 ADDRESS Ferdinand Garcia 7600 Reilly Ave.			
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 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Glomerular Nephritis 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.				INTERVAL BETWEEN ONSET AND DEATH 2-10	
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)	
21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 592X				22. I hereby certify that I attended the deceased from Aug 7, 1950, to Aug 8, 1950, that I last saw the deceased alive on Aug 8, 1950 and that death occurred at 9:30 A.M., from the causes and on the date stated above.	
23a. SIGNATURE B. J. McFerris M.D.		23b. ADDRESS 16 Hampton Village		23c. DATE SIGNED 8/7/50		23d. (Degree or title)	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE Aug 11, 50		24c. NAME OF CEMETERY OR CREMATORY Mt. Hope		24d. LOCATION (City, town, or county) (State) Lemay, Mo	
DATE REC'D BY LOCAL AUG 10 1950		REGISTRAR'S SIGNATURE J. B. Sasater		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Fendler Undk, Co., 7420 Michigan Ave			

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

Dec 5 Pm

mil

P.G. McElin
Hof-Miller

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 J. E. Morris

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 the body is not embalmed, fact should be so stated above.