

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED AUG 25 1950

28600  
State File No. 6984  
Registrar's No.

BIRTH NO. 20767. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <i>Mo</i> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town or town) <i>ST. LOUIS MO.</i>		c. LENGTH OF STAY (In this place)	
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>ST. LOUIS CITY HOSPITAL #1.</i>		c. CITY (If outside corporate limits, write RURAL and give township) <i>St Louis 2269</i>	
		d. STREET ADDRESS (If rural, give location) <i>2809 Blair and</i>	
3. NAME OF DECEASED (Type or Print) a. (First) <i>PETER.</i>		b. (Middle)	
		c. (Last) <i>ROCK.</i>	
		4. DATE OF DEATH (Month) (Day) (Year) <i>AUGUST 16. 1950</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>4-27-1878</i>
9. AGE (In years last birthday) <i>72</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country) <i>Bed. King Man</i>	12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME <i>John Rock</i>		13b. MOTHER'S MAIDEN NAME <i>Anna</i>	
		14. NAME OF HUSBAND OR WIFE <i>Clara</i>	
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 <i>Clara Rock</i> ADDRESS <i>2809 Blair and</i>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Menia</i>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Carcinoma of Prostate</i> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

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? <i>177X</i>

22. I, hereby certify that I attended the deceased from *8/7/1950*, to *8/16/1950*, that I last saw the deceased alive on *8/16/1950*, and that death occurred at *3:40A* m., from the causes and on the date stated above.

23a. SIGNATURE <i>L. Donald Ferry M.D.</i> (Degree or title)	23b. ADDRESS <i>1515 LAFAYETTE AVE</i>	23c. DATE SIGNED <i>8/16/50</i>
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24b. DATE <i>8/17/50</i>	24c. NAME OF CEMETERY OR CREMATORY <i>St Peter</i>
	24d. LOCATION (City, town, or county) (State) <i>St Louis, Missouri</i>	

DATE REC'D BY LOCAL REG. <i>AUG 17 1950</i>	REGISTRAR'S SIGNATURE <i>J. B. Vassler</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Central Pharmacy</i> ADDRESS <i>1841 Cass ave</i>
---	--	---

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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed Ellon R. Benekis

Signed.....  
Student Embalmer

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.