

FILED SEP 16 1950

STANDARD CERTIFICATE OF DEATH

32200

State File No.

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 6076 Registrar's No. 2162

1. PLACE OF DEATH
a. COUNTY Lemay St Louis

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) OR TOWN Lemay

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St Charles 0923

d. FULL NAME OF HOSPITAL OR INSTITUTION MT. ST. ROSE SANATORIUM

d. STREET ADDRESS (If rural, give location) 823 Nathan Ave

3. NAME OF DECEASED
a. (First) Ayao b. (Middle) _____ c. (Last) Kawahara

4. DATE OF DEATH (Month) (Day) (Year) Sept 9 1950

5. SEX M

6. COLOR OR RACE Japanese

7. MARRIED NEVER MARRIED, WIDOWED, DIVORCED (Specify) 1

8. DATE OF BIRTH 4-1-86

9. AGE (In years last birthday) 64

IF UNDER 1 YEAR Days 5

IF UNDER 1 HR. Hours 9 Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant

10b. KIND OF BUSINESS OR INDUSTRY Fruit & Vegetable

11. BIRTHPLACE (State or foreign country) Japan

12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME Yonota

13b. MOTHER'S MAIDEN NAME Unknown

14. NAME OF HUSBAND OR WIFE Okuyama

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. nil

17. INFORMANT'S SIGNATURE OR NAME Hattie M. Kawahara ADDRESS 823 Nathan St. St. Charles

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) Pulmonary Tuberculosis
ANTECEDENT CAUSES Pulmonary Hemorrhage
DUE TO (b) _____
DUE TO (c) _____
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. -

INTERVAL BETWEEN ONSET AND DEATH 16 mo.

NO2X

19a. DATE OF OPERATION _____

19b. MAJOR FINDINGS OF OPERATION _____

20. AUTOPSY? YES NO 002X

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 NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from July 1, 1950, to Sept 9, 1950, that I last saw the deceased alive on Sept 9, 1950, and that death occurred at 10:07 A.M., from the causes and on the date stated above.

23a. SIGNATURE F. E. Foley (Print name or title) _____

23b. ADDRESS mt. st. Rose Sanatorium

23c. DATE SIGNED 9-11-50

24a. BURIAL, CREMATION, REMOVAL (Specify) Crema

24b. DATE Sept 12 1950

24c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery

24d. LOCATION (City, town, or county) (State) St. Louis County Mo.

DATE REC'D BY LOCAL REG. 9-12-50

REGISTRAR'S SIGNATURE Herbert R. Donke M.D.

25. FUNERAL DIRECTOR'S SIGNATURE Gray Miller ADDRESS 5041 Delmar

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

NOV 28 1955

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Roland Yahrke

Signed _____

Student Embalmer

Licensed Embalmer No. 3917

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.