

FILED NOV 24 1950

THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

38936

State File No. \_\_\_\_\_

318

1003

Registrar's No. 9202

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo.</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (in this place) <u>3 days</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u> <u>2069</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Deaconess Hospital</u>				6. STREET ADDRESS (If rural, give location) <u>5308a Wells Ave.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Albert</u> b. (Middle) <u>V.</u> c. (Last) <u>Prost</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 14 1950</u>				
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>		8. DATE OF BIRTH <u>Dec. 13 1882</u>	
9. AGE (In years last birthday) <u>67</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Central Hdy. Co</u>		11. BIRTHPLACE (State or foreign country) <u>Perryville Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13a. FATHER'S NAME <u>Narcis Prost</u>			13b. MOTHER'S MAIDEN NAME <u>Mary Frioux</u>		14. NAME OF HUSBAND OR WIFE <u>Amelia Prost</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>489-09-7644</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Amelia Prost; 5308a Wells Ave.</u>		
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) <u>Coronary thrombosis &amp; Myocardial infarction</u> 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 <u>5 days</u>
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? <u>H2O1</u>			
22. I hereby certify that I attended the deceased from <u>Nov 9</u> , 19 <u>50</u> , to <u>Nov 14</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>Nov 14</u> , 19 <u>50</u> and that death occurred at <u>12:30 p.m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Charles F. Williams M.D.</u>			23b. ADDRESS <u>3903 Olive St. St. Louis</u>		23c. DATE SIGNED <u>11-15-50</u>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		24b. DATE <u>11/17/50</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Valhalla Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Co. Mo.</u>	
DATE REC'D BY LOCAL REG. <u>NOV 13 1950</u>			REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Drehmann-Harral; 1905 Union Blvd.</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

Dr. E. J. Helbing;  
3903 Olive St.;  
(12:30 to 3)

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**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.

Student .....

Student Embalmer

Signed

*Warren A. Carver*

Licensed Embalmer No. *3534*

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.