

FILED SEP 28 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 32090

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 4464 Registrar's No. 3203

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

1. PLACE OF DEATH a. COUNTY St Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY St Louis	
b. CITY (If outside corporate limits, write RURAL and give township) Overland		c. CITY (If outside corporate limits, write RURAL and give township) Overland	
c. LENGTH OF STAY (In this place) 3 mos		21. TOWN Overland	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2814 Stella		d. STREET ADDRESS (If rural, give location) 2814 Stella	

3. NAME OF DECEASED (Type or Print) Randolph Joseph Pfeiler			4. DATE OF DEATH (Month) (Day) (Year) SEP 19 1951		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH June 5 1951		9. AGE (In years last birthday) Months Days 0 3 14
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St Louis Mo	
12. CITIZEN OF WHAT COUNTRY? USA					

13a. FATHER'S NAME Arnold Pfeiler		13b. MOTHER'S MAIDEN NAME Evelyn Adkinson		14. NAME OF HUSBAND OR WIFE	
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 Arnold J Pfeiler Overland 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) Asphyxia			INTERVAL BETWEEN ONSET AND DEATH Acute
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) none			
		DUE TO (c) acute tracheobronchial obstruction due to regurgitation of food			
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) Accident		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Overland		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis Mo	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 9 19 51 10:40A.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Acute tracheobronchial obstruction due to regurgitation of food during sleep	

22. I hereby certify that I attended the deceased from **Aug**, 19**51**, to **Sept**, 19**51**, and that I last saw the deceased alive on **9-17**, 19**51**; and that death occurred at **10:40A m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) S. P. ... M.D.		23b. ADDRESS Overland, Mo.		23c. DATE SIGNED 9-20-51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 9/21/51		24c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cem	
				24d. LOCATION (City, town, or county) (State) St Louis Mo	

DATE REC'D BY LOCAL REG. 9-21-51		REGISTRAR'S SIGNATURE Herbert K. ... MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ortmann F Home 9222 Lackland Overland Mo	
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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 _____

working under my personal supervision.

Student Embalmer No.

Signed *Alb. C. Ostmann*

Signed.....
Student Embalmer

Licensed Embalmer No. *3478*

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.