

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

39430

State File No.

FILED DEC 8 - 1951

BIRTH NO. REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 10610

2018
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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) c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>ST LOUIS</u> <u>2129</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>PRONOUNCED-DEAD-CITY-HOSP</u>		d. STREET ADDRESS (If rural, give location) <u>5005 CARRANNE AVE</u>	

3. NAME OF DECEASED (Type or Print) <u>James J. Meade</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>11-25-51</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>JULY 13 - 1887</u>	9. AGE (In years last birthday) <u>64</u>	IF UNDER 1 YEAR Months Days IF UNDER 6 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BONTERRE MO</u>	
12. CITIZEN OF WHAT COUNTRY?						

13a. FATHER'S NAME <u>UNKNOWN</u>	13b. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>	16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Mr Repede</u>	ADDRESS <u>2331 Mullonphy</u>
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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, ashenia, etc. It means the disease, injury, or complication which caused death.</i>	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		INTERVAL BETWEEN ONSET AND DEATH
	ANTECEDENT CAUSES DUE TO (b) <u>Pulmonary Oedema</u> DUE TO (c) <u>Aortic Aneurysm</u>		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Cardiac Hypertrophy</u>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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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>O22X</u>
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22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 11:17 P.M., from the causes and on the date stated above.

23a. SIGNATURE <u>Med Repede</u>	(Degree or title)	23b. ADDRESS <u>1300 Clark</u>	23c. DATE SIGNED <u>11/29/51</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>NOV-29-51</u>	24c. NAME OF CEMETERY OR CREMATORY <u>CALVARY</u>	24d. LOCATION (City, town, or county) (State) <u>ST LOUIS MO</u>
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DATE REC'D BY LOCAL REG. <u>NOV 29 1951</u>	REGISTRAR'S SIGNATURE <u>Paul Smith</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Charles Kellie</u>	ADDRESS <u>14386 Lumbell</u>
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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 _____

Students of Mortuary College

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed *James A. Lammers*

Licensed Embalmer No. *4142*

P. O. Address *St Louis*

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.