No. 300
10-48

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

FILED APR 12 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 9837

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 3037

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis, Missouri
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Louis City Hospital #1

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Louis 2259
d. STREET ADDRESS (If rural, give location) 2 819½ Market

3. NAME OF DECEASED (Type or Print)
a. (First) EDWIN
b. (Middle)
c. (Last) CORDZ

4. DATE OF DEATH (Month) (Day) (Year) MARCH 14, 1952

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH July 22, 1897
9. AGE (In years last birthday) 54 — 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) None
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Louis
13b. MOTHER'S MAIDEN NAME Sadie
14. NAME OF HUSBAND OR WIFE --

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. Unknown
17. INFORMANT'S SIGNATURE OR NAME Hospital Record ADDRESS

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Polyarteritis nodosa — INTERVAL BETWEEN ONSET AND DEATH 2 mos.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c) Chronic alcoholism

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Laennec's cirrhosis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION Peritonitis, chronic cholecystitis
20. AUTOPSY? YES ☐ NO ☒

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) -- -- m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 456.X

22. *I hereby certify that I attended the deceased from* 1-8552, 19____, *to* 3-14-52, 19____, *that I last saw the deceased alive on* 3-14-52, 19____, *and that death occurred at* 1:45P *m., from the causes and on the date stated above.*

23a. SIGNATURE Andrew L. Hahn (Degree or title) M.D.
23b. ADDRESS 1515 Lafayette Avenue
23c. DATE SIGNED 3-14-52

24a. BURIAL, CREMATION, REMOVAL (Specify) B
24b. DATE MAR 3 1 1952
24c. NAME OF CEMETERY OR CREMATORY Anatomical Board
24d. LOCATION (City, town, or county) St. Louis, Mo. (State)

DATE REC'D BY LOCAL REG. MAR 3 1 1952
REGISTRAR'S SIGNATURE J. Carl Smith M.D. M.B.
25. FUNERAL DIRECTOR'S SIGNATURE Rowland ADDRESS 4104 Manchester

(Licensed Embalmer's Statement on Reverse Side)

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 .....

Licensed Embalmer No. .....

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.