

STANDARD CERTIFICATE OF DEATH

State File No.

FILED MAR 29 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **2241**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis 2109	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 10 4385 St. Louis Ave.	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4385 St. Louis Ave.			

3. NAME OF DECEASED (Type or Print) George Waford			4. DATE OF DEATH (Month) (Day) (Year) March - 6 1952		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 9	
8. DATE OF BIRTH unknown		9. AGE (In years last birthday) 81		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Indiana	
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME unknown		13b. MOTHER'S MAIDEN NAME unknown	
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)		16. SOCIAL SECURITY NO. 491-16-7197	
17. INFORMANT'S SIGNATURE OR NAME Mrs. Clyde Warder		ADDRESS 9233 Edna Ave.			

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) _____ ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Coronary Occlusion DUE TO (c) Arterio sclerosis				INTERVAL BETWEEN ONSET AND DEATH	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
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) (m.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? H501	

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 **2:10 p.m.**, from the causes and on the date stated above.

23a. SIGNATURE Patrick E. Taylor, Coroner		(Degree or title)		23b. ADDRESS 1500 Clair		23c. DATE SIGNED MAR 9 1952	
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE 3/8/52		24c. NAME OF CEMETERY OR CREMATORY Valhalla		24d. LOCATION (City, town, or county) (State) St. Louis County	

DATE REC'D BY LOCAL REG. MAR 10 1952		REGISTRAR'S SIGNATURE Carl Smith MO		25. FUNERAL DIRECTOR'S SIGNATURE Sullivan's		ADDRESS 2849 No. Euclid Ave	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

705

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 _____

Not embalmed

working under my personal supervision.

Student Embalmer No.....

Signed

Sullivan Edw G.

Signed.....

Student Embalmer

Licensed Embalmer No.....

P. O. Address *2849 N. Cedar*

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.