

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **16320**
Registrar's No. **3481**

ED APR 18 1953

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1008**

1. PLACE OF DEATH a. COUNTY St. Louis, Waldemar		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. COUNTY Dunklin	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN (St. Louis, Missouri)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Route No. 1 Malden 0350	
d. FULL NAME OF HOSPITAL OR INSTITUTION 6904 Waldemar		d. STREET ADDRESS (If rural, give location) 1	

3. NAME OF DECEASED (Type or Print) a. (First) Aziel b. (Middle) Knox c. (Last) Verdier			4. DATE OF DEATH (Month) (Day) (Year) 3 31 53		
5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 4--2--1870	9. AGE (In years) (last birthday) 82	10. UNDER 1 YEAR Months
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Lincoln Co. Mo.	
12. CITIZEN OF WHAT COUNTRY? U.S.A					

13a. FATHER'S NAME Charuald Verdier		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Addie Verdier	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Stanley Anderson 6904 Waldemar	

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) Anterior chest (Heart Disease) ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Anterior chest DUE TO (c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Bronchiectasis				INTERVAL BETWEEN ONSET AND DEATH	
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)		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? 4200	

22. I hereby certify that I attended the deceased from _____, 19____, to **March 31, 1953**, that I last saw the deceased alive on **March 29, 1953**, and that death occurred at **3:15 P. m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Walter A. Dill M.D.		23b. ADDRESS 7896 Hawthorne Ave. Maplewood, Mo.		23c. DATE SIGNED 4-1-53	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 4-1-53		24c. NAME OF CEMETERY OR CREMATORY Corning, Arkansas	

DATE REC'D BY LOCAL REG. APR 1 1953		REGISTRAR'S SIGNATURE J. Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Russel F.H. Corning Ark.	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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. 4366

P. O. Address. W. Wood

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.