No. 300
10.48

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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3152

State File No. .....

FILED FEB 2 1954

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 0750

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

1. PLACE OF DEATH
a. COUNTY

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (in this place): 3 wks

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): New Faith Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY

c. CITY OR TOWN: St. Louis
d. Is Residence within limits of a city or incorporated town? Yes ☐ No ☐

e. STREET ADDRESS (If rural, give location): 10 4133 Peck Street 2109

3. NAME OF DECEASED (Type or Print)
a. (First): John
b. (Middle): H.
c. (Last): Pape

4. DATE OF DEATH (Month) (Day) (Year): 1 - 22 -1954

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 12 - 28 -1871
9. AGE (In years last birthday): 82 — 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): Floorman
10b. KIND OF BUSINESS OR INDUSTRY: Furniture Co.
11. BIRTHPLACE (City and State or Foreign Country): St. Louis, Missouri
12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME: Christ E. Pape
13b. MOTHER'S MAIDEN NAME: Katherine Lammert
14. NAME OF HUSBAND OR WIFE: Theresa M. Pape

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 488-07-1950
17. INFORMANT'S SIGNATURE OR NAME / ADDRESS: Mrs. Theresa M. Pape, 4133 Peck St.

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) Carcinoma of Caecum c̄ liver metastasis — INTERVAL BETWEEN ONSET AND DEATH: 6 mo.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Anemia severe sec to intestinal bleeding — 6 mo.
DUE TO (c) Cardiac failure — 3 days

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Arteriosclerotic ~~[illegible]~~ generalized — 10 yr.

19a. DATE OF OPERATION: 1/15/54
19b. MAJOR FINDINGS OF OPERATION: Carcinoma of Caecum c̄ liver Metastasis
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? 153X

22. *I hereby certify that I attended the deceased from* 7/6/52, 19__, *to* 1/22, 1954, *that I last saw the deceased alive on* 1/22, 1954, *and that death occurred at* 8:55P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): S Ciapciol MD
23b. ADDRESS: 1901 Madison St
23c. DATE SIGNED: 1/23/54

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 1/25/54
24c. NAME OF CEMETERY OR CREMATORY: Zion Cemetery
24d. LOCATION (City, town, or county) (State): St. Louis County Mo.

DATE REC'D BY LOCAL REG.: JAN 25 1954
REGISTRAR'S SIGNATURE: J Earl Smith MD MJB
25. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Drehmann-Harral 1905 Union Blvd.

(Licensed Embalmer's Statement on Reverse Side)

Dr. G. J. Crapciak
1901 Madison
Sat. - 12 to 5
Mon. - 12 to 4

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was emb

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.