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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **13901**
3648
Registrar's No. _____

FILED APR 29 1954

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

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) OR TOWN ST. LOUIS, MO	c. LENGTH OF STAY (In this place) 23 days	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 2140	
d. FULL NAME OF HOSPITAL OR INSTITUTION MISSOURI PACIFIC HOSP.		d. STREET ADDRESS (If rural, give location) 14 5468 MARQUETTE	

3. NAME OF DECEASED (Type or Print) a. (First) ALPHONSE b. (Middle) JOHN c. (Last) OLDEG			4. DATE OF DEATH (Month) (Day) (Year) APR. 21-1954		
5. SEX MALE	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH Nov. 2, 1888		9. AGE (In years last birthday) 65
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MO. PAC. EMPLOYEE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) ST. LOUIS, MO.		12. CITIZEN OF WHAT COUNTRY? U.S.

13a. FATHER'S NAME HENRY OLDEG		13b. MOTHER'S MAIDEN NAME CLARA BUSH		14. NAME OF HUSBAND OR WIFE OLIVIA OLDEG	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) W.W. I	16. SOCIAL SECURITY NO. 702-14-1807		17. INFORMANT'S SIGNATURE OR NAME OLIVIA OLDEG ADDRESS 5468 MARQUETTE 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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia			INTERVAL BETWEEN ONSET AND DEATH
		ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
		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 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) 154X		
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			

22. I hereby certify that I attended the deceased from **3-29, 1954** to **4-21, 1954**, that I last saw the deceased alive on **4-21, 1954**, and that death occurred at **6:00 A.M.**, from the causes and on the date stated above.

23a. SIGNATURE W. F. Melick (Degree or title) M.D.		23b. ADDRESS 1755 S. Grand		23c. DATE SIGNED 4-22-54	
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 4-23-1954	24c. NAME OF CEMETERY OR CREMATORY CALVARY CEM.	24d. LOCATION (City, town, or county) (State) ST. LOUIS, MO.		

DATE REC'D BY LOCAL REG. APR 22 1954	REGISTRAR'S SIGNATURE J. Earl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE KRIEGSHAUSER ADDRESS 4228 S. KINGS HIGHWAY		
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S.P. (Licensed Embalmer's Statement on Reverse Side)

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

JAN 13 1958

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 Richard W. Stovesan

Licensed Embalmer No. 4007

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.