No. 300
10-46

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

FILED OCT 13 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31406

BIRTH NO. _____ REG. DIST. NO. 276 440 PRIMARY REG. DIST. NO. 4410 276 Registrar's No. 45

1. PLACE OF DEATH
a. COUNTY Phelps
b. CITY OR TOWN St. James
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) Soldiers Home Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Missouri
b. COUNTY Phelps
c. CITY OR TOWN St. James
d. Is Residence within limits of a city or incorporated town? Yes ☒ No ☐
e. STREET ADDRESS (If rural, give location) D 8 110 d

3. NAME OF DECEASED (Type or Print)
a. (First) John
b. (Middle) A.
c. (Last) Egli

4. DATE OF DEATH (Month) Oct (Day) 7 (Year) 1954

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) unknown
8. DATE OF BIRTH June 24 1877
9. AGE (In years last birthday) 77 IF UNDER 1 YEAR Months 3 Days 13 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown
10b. KIND OF BUSINESS OR INDUSTRY unknown
11. BIRTHPLACE (City and State or Foreign Country) Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME unknown
13b. MOTHER'S MAIDEN NAME unknown
14. NAME OF HUSBAND OR WIFE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) Spanish Am.
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE OR NAME ADDRESS Soldires Home St. James, Mo.

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 Sigmoid
DUE TO (b) with Metastasis
DUE TO (c)

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

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH
Indefinite

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION 153 X
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?

22. *I hereby certify that I attended the deceased from* June 20, 1953, *to* Oct 7, 1954, *that I last saw the deceased alive on* 10-7, 1954, *and that death occurred at* 10:55 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Josh. Grosskreutz (Degree or title) MD
23b. ADDRESS St. James, Mo.
23c. DATE SIGNED 10-8-54

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal
24b. DATE 10-11-54
24c. NAME OF CEMETERY OR CREMATORY Memorial Park
24d. LOCATION (City, town, or county) Maplewood, Mo. (State) St. Louis Mo

DATE REC'D BY LOCAL REG. 10-8-57
REGISTRAR'S SIGNATURE Ruth B. Powell 479
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS C. Jesse Baker St. James Mo.

(Licensed Embalmer's Statement on Reverse Side)

OCT 14 19

STATEMENT BY LICENSED EMBALMER

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

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

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed C. Jesse Gahr

Licensed Embalmer No. 4486

P. O. Address St. James, I

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Fai 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.