

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

32106

State File No. _____

Registrar's No. **8018**

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 Missouri b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city (incorporated town)? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis City Hospital		e. STREET ADDRESS (If rural, give location) 5151 Washington Blvd.,	

3. NAME OF DECEASED (Type or Print) a. (First) Edward b. (Middle) Daniel c. (Last) Posz			4. DATE OF DEATH (Month) (Day) (Year) August 28 1954		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH April 18 1878	9. AGE (In years last birthday) 76	10. UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Cabinet Maker Cabinets		10b. KIND OF BUSINESS OR INDUSTRY Cabinets	11. BIRTHPLACE (City and State or Foreign Country) Shelbyville, Indiana		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME George Adam Posz	13b. MOTHER'S MAIDEN NAME Christine Mohr	14. NAME OF HUSBAND OR WIFE Nil
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) Nil	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Elizabeth Posz, Henderson Kentucky

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		INTERVAL BETWEEN ONSET AND DEATH 6 days
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Cerebral Encephalomalacia		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Axial thrombosis DUE TO (c) Cerebral arteriosclerosis		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Generalized arteriosclerosis Hypertensive vascular disease		III. OTHER SIGNIFICANT CONDITIONS Chemic	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> 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 <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 334X

22. I hereby certify that I attended the deceased from 8-22-54, 19, to 8-28-54, 19, that I last saw the deceased alive on 8-28-54, 19, and that death occurred at 4:00P. m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Joseph M. Schuster Jr. M.D.		23b. ADDRESS St. Louis City Hospital		23c. DATE SIGNED 8-29-54
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 8-29-54	24c. NAME OF CEMETERY OR CREMATORY Forest Hill Cemetery	24d. LOCATION (City, town, or county) (State) Shelbyville, Indiana	
DATE REC'D BY LOCAL REG. AUG 31 1954	REGISTRAR'S SIGNATURE J. Earl Smith M.D.	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe, 4700 Washington Blvd		

S.D. (Licensed Embalmer's Statement on Reverse Side)

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

No. 300
10-48

FILED SEP 16 1954

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.....
Signature of Student Embalmer

Signed *J W M B*.....
Licensed Embalmer No. *365*.....
P. O. Address *St Louis*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.