

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35917**
9609
Registrar's No.

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 OR TOWN St. Louis	c. LENGTH OF STAY (in this place)	c. CITY OR TOWN St. Louis	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION: 1919 So. Grand		e. STREET ADDRESS (If rural, give location) 17 1919 So. Grand 2119	

3. NAME OF DECEASED (Type or Print) a. (First) Alfred b. (Middle) R. St. John c. (Last) Se.	4. DATE OF DEATH (Month) (Day), (Year) Oct. 22 54
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5. SEX M	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) M	8. DATE OF BIRTH Oct. 23 1898	9. AGE (In years last birthday) 56	# UNDER 1 YEAR Days 11	# UNDER 1 YEAR Hours 39	# UNDER 1 YEAR Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R. E. organizer for union clerks	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) St. Louis	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Mac St. John	13b. MOTHER'S MAIDEN NAME Mary Michel	14. NAME OF HUSBAND OR WIFE Dazel
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. no	17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS Mrs. H. St. John 1919 So. Grand
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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
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary failure		1 mo.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Myocardial infarction DUE TO (c)		8 mos.
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"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 4201
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22. I hereby certify that I attended the deceased from **Feb 54**, 19**54**, to **10/12 54**, 19**54**, that I last saw the deceased alive on **10/12 1954**, and that death occurred at **7:30 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) R. C. Treiman	23b. ADDRESS Mo. Pacific Hospital	23c. DATE SIGNED 10/23/54
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Oct. 25 54	24c. NAME OF CEMETERY OR CREMATORY Memorial Park	24d. LOCATION (City, town, or county) (State) St. Louis County Mo
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DATE REC'D BY LOCAL REG. OCT 23 1954	REGISTRAR'S SIGNATURE J. Carl Smith - MD	25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS Jos. A. Howard 1619 So. Grand
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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.....
Signature of Student Embalmer

Signed..... *Paul A. Wachter*

Licensed Embalmer No. *478*

P. O. Address *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.