

FILED DEC 30 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42337

State File No.

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

Registrar's No. **10730**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <i>Mo.</i> b. COUNTY <i>St. Louis</i>	
b. CITY (If outside corporate limits, write RURAL and give township)		c. CITY (If outside corporate limits, write RURAL and give township) <i>Remay 4850</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>Alexian Bros. Hosp</i>		d. STREET ADDRESS (If rural, give location) <i>Rt 11 Box 350</i>	
3. NAME OF DECEASED a. (First) <i>ERWIN</i> b. (Middle) <i>Joseph</i> c. (Last) <i>Dust.</i>		4. DATE OF DEATH (Month) (Day) (Year) <i>11 21 1954</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>11-16-1911</i>
9. AGE (In years last birthday) <i>43</i>		IF UNDER 1 YEAR Months <i>5</i>	IF UNDER 1 HRs. Min. <i>5</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Pipe Fitter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Monsanto Chem.</i>	
11. BIRTHPLACE (State or foreign country) <i>St. Louis</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13a. FATHER'S NAME <i>William C. Dust</i>		13b. MOTHER'S MAIDEN NAME <i>Katherine Kramer</i>	
14. NAME OF HUSBAND OR WIFE <i>Clotilda Ziegler</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>497-01-4698</i>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <i>Clotilda Dust. Rt 11 Box 350 Remay</i>	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Cardiac Dilatation</i> INTERVAL BETWEEN ONSET AND DEATH <i>Several hrs.</i> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>chronic cardiac-vascular disease</i> DUE TO (c) <i>Coronary of liver</i> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Several months</i>	
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)	
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? <i>442x</i>		22. I hereby certify that I attended the deceased from <i>Aug. 15</i> , 19 <i>54</i> , to <i>Nov. 21</i> , 19 <i>54</i> , that I last saw the deceased alive on <i>11-21</i> , 19 <i>54</i> , and that death occurred at <i>7:30 P.M.</i> , from the causes and on the date stated above.	
23a. SIGNATURE <i>Erwin S. Gendries M.D.</i>		23b. ADDRESS <i>752 Leivay Ferry Rd</i>	
23c. DATE SIGNED <i>11.23.54</i>		24a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	
24b. DATE <i>11-26-1954</i>		24c. NAME OF CEMETERY OR CREMATORY <i>S.S. Peter & Paul</i>	
24d. LOCATION (City, town, or county) (State) <i>St. Louis Mo.</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Carl Smith</i>	
DATE REC'D BY LOCAL REG. <i>NOV 24 1954</i>		REGISTRAR'S SIGNATURE <i>Carl Smith</i>	
25. FUNERAL DIRECTOR'S SIGNATURE <i>Carl Smith</i>		ADDRESS <i>3819 So Grand Blvd.</i>	

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
Student Embalmer

Signed

Geo. J. McInghern

..... Licensed Embalmer No. *4617*

P. O. Address *H. House*

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.