

FILED MAR 31 1955

## STANDARD CERTIFICATE OF DEATH

State File No. 9539

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 2274

|                                                                                                                                                                                                                                 |  |                                                                                          |                                                                                                        |                                                                                                                                                               |                                                                                      |                                                                                                                                      |                                                        |                                                                                                  |                                                                                     |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|--------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY                                                                                                                                                                                                  |  |                                                                                          |                                                                                                        | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)<br>a. STATE MISSOURI b. COUNTY ST LOUIS                                |                                                                                      |                                                                                                                                      |                                                        |                                                                                                  |                                                                                     |  |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN ST LOUIS,                                                                                                                                       |  | c. LENGTH OF STAY (in this place)                                                        |                                                                                                        | c. CITY OR TOWN ST LOUIS, MO                                                                                                                                  |                                                                                      | d. Is Residence within limits of a city or incorporated town?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |                                                        |                                                                                                  |                                                                                     |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br>DST. JOHN'S HOSPITAL                                                                                                                                                                 |  |                                                                                          |                                                                                                        | STREET ADDRESS (If rural, give location)<br>4731 ROSALIE AVE 20790                                                                                            |                                                                                      |                                                                                                                                      |                                                        |                                                                                                  |                                                                                     |  |
| 3. NAME OF DECEASED<br>(Type or Print)<br>a. (First) THEODORE                                                                                                                                                                   |  |                                                                                          | b. (Middle) A.                                                                                         |                                                                                                                                                               | c. (Last) DRESLER                                                                    |                                                                                                                                      | 4. DATE OF DEATH (Month) (Day) (Year)<br>MARCH 8, 1955 |                                                                                                  |                                                                                     |  |
| 5. SEX<br>MALE                                                                                                                                                                                                                  |  | 6. COLOR OR RACE<br>WHITE                                                                |                                                                                                        | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br>MARRIED                                                                                             |                                                                                      | 8. DATE OF BIRTH<br>MAY 27, 1890                                                                                                     |                                                        | 9. AGE (In years last birthday) 64<br>IF UNDER 1 YEAR Months Days<br>IF UNDER 24 HRS. Hours Min. |                                                                                     |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>MEAT CUTTER                                                                                                                      |  |                                                                                          | 10b. KIND OF BUSINESS OR INDUSTRY                                                                      |                                                                                                                                                               |                                                                                      | 11. BIRTHPLACE (City, and State or Foreign Country)<br>HARRISONVILLE ILLINOIS                                                        |                                                        | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                                           |                                                                                     |  |
| 13a. FATHER'S NAME<br>LOUIS DRESLER                                                                                                                                                                                             |  |                                                                                          | 13b. MOTHER'S MAIDEN NAME<br>ANNA SONDAG                                                               |                                                                                                                                                               |                                                                                      | 14. NAME OF HUSBAND OR WIFE<br>ELIZABETH DRESLER                                                                                     |                                                        |                                                                                                  |                                                                                     |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br>NO                                                                                                                  |  |                                                                                          | 16. SOCIAL SECURITY NO.<br>#488-20-3774                                                                |                                                                                                                                                               | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br>ELIZABETH DRESLER 4731 ROSALIE AVE      |                                                                                                                                      |                                                        |                                                                                                  |                                                                                     |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*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<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic lymphatic leukemia                                                    |                                                                                      |                                                                                                                                      |                                                        | INTERVAL BETWEEN ONSET AND DEATH<br>4 1/2 years                                                  |                                                                                     |  |
|                                                                                                                                                                                                                                 |  |                                                                                          |                                                                                                        | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____ |                                                                                      |                                                                                                                                      |                                                        |                                                                                                  |                                                                                     |  |
|                                                                                                                                                                                                                                 |  |                                                                                          |                                                                                                        | II. OTHER SIGNIFICANT CONDITIONS<br>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?<br>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?<br>2040                                                                                                   |                                                        |                                                                                                  |                                                                                     |  |
| 22. I hereby certify that I attended the deceased from Oct. 20, 1948, to March 8, 1955, that I last saw the deceased alive on March 8, 1955, and that death occurred at 8:00 pm., from the causes and on the date stated above. |  |                                                                                          |                                                                                                        |                                                                                                                                                               |                                                                                      |                                                                                                                                      |                                                        |                                                                                                  |                                                                                     |  |
| 23a. SIGNATURE (Degree or title)<br>John J. Smith M.D.                                                                                                                                                                          |  |                                                                                          |                                                                                                        | 23b. ADDRESS<br>4703 Carter Ave. St. Louis                                                                                                                    |                                                                                      |                                                                                                                                      | 23c. DATE SIGNED<br>3-10-55                            |                                                                                                  |                                                                                     |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify)<br>BURIAL                                                                                                                                                                             |  | 24b. DATE<br>3/14/55                                                                     |                                                                                                        | 24c. NAME OF CEMETERY OR CREMATORY<br>RESSUOLVARY CEMETERY                                                                                                    |                                                                                      | 24d. LOCATION (City, town, or county) (State)<br>ST LOUIS MISSOURI                                                                   |                                                        |                                                                                                  |                                                                                     |  |
| DATE REC'D BY LOCAL REG.<br>MAR 12 1955                                                                                                                                                                                         |  | REGISTRAR'S SIGNATURE<br>J. Carl Smith M.D.                                              |                                                                                                        |                                                                                                                                                               | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br>STROOT - CARROLL 4600 NATURAL BRIDGE AVE |                                                                                                                                      |                                                        |                                                                                                  |                                                                                     |  |

(Licensed Embalmer's Statement on Reverse Side)

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: *Oliver R. Sadwell*

Licensed Embalmer No. *407*

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.