

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

19837

State File No. _____
REGISTRAR'S No. **5044**

FILED JUN 30 1955

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| BIRTH NO. _____ | | REG. DIST. NO. 318 | | PRIMARY REG. DIST. NO. 1003 | | REGISTRAR'S No. 5044 | | | |
| 1. PLACE OF DEATH a. COUNTY _____ | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY St. Louis | | | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | c. LENGTH OF STAY (In this place) _____ | | c. CITY OR TOWN Webster Groves | | 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 City Hospital | | | | STREET ADDRESS (If rural, give location) 933 Tuxedo | | | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) VELORUS EBEN b. (Middle) ANDREWS c. (Last) _____ | | | 4. DATE OF DEATH 6-9-1955 (Month) (Day) (Year) | | | | | | |
| 5. SEX M | | 6. COLOR OR RACE W | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | | 8. DATE OF BIRTH 4-15-1897 | | | |
| 9. AGE (In years last birthday) 58 | | IF UNDER 1 YEAR Months _____ Days _____ | | IF UNDER 24 HRS. Hours _____ Min. _____ | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer | | | 10b. KIND OF BUSINESS OR INDUSTRY A.C.F. Industry | | 11. BIRTHPLACE (City and State, or Foreign Country) Greenfield Mass. | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13a. FATHER'S NAME William S Andrews | | | 13b. MOTHER'S MAIDEN NAME Lucy Ladd | | 14. NAME OF HUSBAND OR WIFE Harriett Andrews | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO. W.W.# 1 | | 17. INFORMANT'S SIGNATURE OR NAME Wm. B. Andrews ADDRESS 933 Tuxedo | | | | | |
| 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 | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) _____ | | | | Coronary Thrombosis | | | | | |
| ANTECEDENT CAUSES | | | | Morbidity conditions, if any, giving DUE TO (b) _____ | | | | | |
| | | | | DUE TO (c) _____ | | | | | |
| 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"/> | | | |
| 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? 4201 | | | | | |
| 22. I hereby certify that I attended the deceased from 12-15-1941 , to 5-14-1955 , that I last saw the deceased alive on 5-14-1955 , and that death occurred at 9:15 P.M. , from the causes and on the date stated above. | | | | | | | | | |
| 23a. SIGNATURE (If group or title) Charles C. Grace, M.D. | | | | 23b. ADDRESS 19 E. Lockwood | | 23c. DATE SIGNED 6/9/55 | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24b. DATE 6-13-1955 | | 24c. NAME OF CEMETERY OR CREMATORY Local | | 24d. LOCATION (City, town, or county) (State) Greenfield Mass. | | | |
| DATE REC'D BY LOCAL REG. JUN 10 1955 | | REGISTRAR'S SIGNATURE J. Earl Smith, M.D. | | 25. FUNERAL DIRECTOR'S SIGNATURE Parker Aldrich ADDRESS 7 Home Webster Groves Mo. | | | | | |

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

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

AUG 1 1955

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.....
Leslie Welch

Licensed Embalmer No. *437*

P. O. Address *Webster St*

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.