

FILED SEP 6 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.
27967
6904

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
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 St. Louis
d. FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or Print) WILLIAM		a. (First) A.	b. (Middle) METZ
c. (Last)		4. DATE OF DEATH (Month) (Day) (Year) Aug. 7 1955	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 19, 1895
9. AGE (In years last birthday) 60		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman-Cahokia Plant-Union Electric Co.	11. BIRTHPLACE (City and State or Foreign Country) Sikeston, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13a. FATHER'S NAME George Metz	
13b. MOTHER'S MAIDEN NAME Caroline Bavis		14. NAME OF HUSBAND OR WIFE Ellen E. Metz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME Ellen E. Metz		ADDRESS 6931 Clifton Ave.	
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) HEAT STROKE (THERMAL) INTERVAL BETWEEN ONSET AND DEATH: 24 hrs. ANTECEDENT CAUSES DUE TO (b) APPENDICITIS (APPENDECTOMY) DUE TO (c) O.K. Joseph M. Zuercher II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION 8/2/55		19b. MAJOR FINDINGS OF OPERATION Acute Retrocecal Appendix.	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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?			
22. I hereby certify that I attended the deceased from 8/2 , 19 55 , to 8/7 , 19 55 , that I last saw the deceased alive on 8/7 , 19 55 , and that death occurred at 11:45 P.M. , from the causes and on the date stated above.			
23a. SIGNATURE Robert H. Larson, M.D.		23b. ADDRESS 3606 Darrow	
23c. DATE SIGNED 8/8/55			
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE Aug. 10, 1955	
24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park		24d. LOCATION (City, town, or county) (State) St. Louis, Co. Mo.	
DATE REC'D BY LOCAL REG. AUG 8 1955		REGISTRAR'S SIGNATURE J. Carl Smith, M.D.	
25. FUNERAL DIRECTOR'S SIGNATURE Kriegshauser		ADDRESS 4228 S. Kingshighway Bl.	

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 *Richard W. Storres*.....

Licensed Embalmer No. *400*.....

P. O. Address

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.